Office of the Inspector General

Department of Mental Health, Mental Retardation And Substance Abuse Services

Semi - Annual Report
April 1, 2003 – September 30, 2003

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FORWARD

The Office of the Inspector General for the Department of Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semiannual report of activities for the period ending on September 30, 2003. This report is issued in accordance with the provisions of VA § 2.1- 816.1, which specifies that the Office report on the significant issues related to the administration of the publicly funded services system.

Among the activities completed by the OIG during this reporting period, which began on April 1, 2003, has been the completion of seven unannounced inspections; the preparation of nine reports; the on-going monitoring of critical incidents; and a review of monthly systemic data submitted by the fifteen state facilities on issues such as staff injuries, human rights complaints and the use of restrictive interventions such as seclusion and restraint as well as a review of deaths.

The Office of the Inspector General completed six goals meetings with groups of consumers and advocates across the Commonwealth between May and July 2003. The purpose of these meetings was to update consumers on the work of the Office and to provide them with an opportunity to share thoughts and experiences regarding the delivery of services within their respective regions. Those attending were knowledgeable and well informed. The groups spoke of the importance of being able to actively participate in the development of their treatment and recovery process.

Anita S. Everett, M.D. resigned her position as the Inspector General on September 15, 2003. Her dedication to the work of this office was widely recognized and appreciated.

The OIG maintains its commitment to ensuring through continuous quality improvement efforts that consumers and their families receive the care and support they deserve.

HIGHLIGHT OF ACTIVITIES

- **Seven unannounced inspections** were conducted, which included four snapshot inspections and three secondary reviews.

- **Nine reports were completed.** Six have been released for posting to the office website and the remaining three are currently in the review process.

- The Office of the Inspector General **completed six goals meetings** across the Commonwealth with consumers and advocates. Two were conducted in the Northern Virginia area, two in Hampton Roads, one in Charlottesville and one in the Southwestern Virginia Region.

- This office **reviewed approximately 689 critical incidents** during this six-month period. An **additional follow-up of 185 of the critical incidents occurred.**

- Monthly quantitative data was received and reviewed from the fifteen state operated facility. **12 follow-up inquiries were completed** regarding this data.

- The OIG was **involved in 3 special project committees.**

- **10 reviews** of Departmental Instructions and other DMHMRSAS documents were completed during this reporting period.

- There were a number of opportunities for this office to participate in activities relevant to the mental health, mental retardation and substance abuse services community through the completion of **13 presentations within the state and nationally.**

ACTIVITIES OF THE OFFICE

A. INSPECTIONS

The OIG conducted seven unannounced inspections during this reporting period. The reports include four snapshot inspections and three secondary reviews. The OIG performs at least one unannounced inspection at each of the fifteen state facilities operated by DMHMRSAS annually based on the calendar year.

A Snapshot inspection encompasses at a minimum a review of the physical conditions of the facility, staffing patterns and patient activities. Each report identifies findings and provides recommendations for improvement to observations made by the Inspector General's staff. A snapshot inspection was conducted at each of the following facilities:

Central Virginia Training Center in Lynchburg
Hiram W. Davis Medical Center in Petersburg
Southeastern Virginia Training Center in Chesapeake
Southwestern Virginia Training Center in Hillsville

Three secondary inspections were conducted. A secondary inspection is conducted in response to a specific concern or complaint received by the office. Secondary inspections often involve patient specific and confidential information. As a result, the corresponding reports are generally not released to the OIG website. Secondary inspections were completed at the following facilities in this six-month reporting period:

Central State Hospital in Petersburg
Southside Virginia Training Center in Petersburg
Commonwealth Center for Children and Adolescents in Staunton

B. REPORTS

The OIG has completed nine reports during this reporting period. Reports are generated as a tool for performance improvement and provide DMHMRSAS with findings and recommendations regarding observations of a number of quality indicators. A Plan of Correction (POC) is made for each recommendation made within an OIG inspection report. Implementation of the plan of correction is monitored until successful resolution has occurred.

The reports are as follows:

Southern Virginia Mental Health Institute #79-03
Eastern State Hospital #80-03

Southside Virginia Training Center / Report #81-03
Southeastern Virginia Training Center / Report #82-03
Central Virginia Training Center / Report #83-03
Southwestern Virginia Training Center / Report #84-03
Hiram W. Davis Medical Center / Report #85-03
Central State Hospital / Report #86-03
Commonwealth Center / Report #87-03

The reports upon release from the Governor's Office are posted to the OIG website except for those which contain specific identifying consumer information or are designated as peer review documents. Six of these reports have been reviewed and five of the snapshot inspections were released for posting on the office website. The secondary inspection conducted at SVTC was not released as recommended by this office. The remaining three reports are currently in the review process.

C. SPECIAL PROJECTS

Statewide Goals Meetings with Consumers and Advocates

The Office of the Inspector General completed six goals meetings with groups of consumers and advocates across the Commonwealth. The purpose of these meetings was to update consumers on the work of the Office and to provide them with an opportunity to share thoughts and experiences regarding the delivery of services within their respective regions. Two meetings occurred in the Northern Virginia area, two in the Tidewater area, one in Charlottesville, and one in the Southwestern Virginia region. Approximately 125 individuals participated in the discussions. The consumer and advocacy groups were very receptive to the opportunity to discuss both the strengths and limitations of the system. Those attending were knowledgeable and well informed. The groups spoke of the importance of being able to actively participate in the development of their treatment and recovery process. A summary of the Goals Meeting can be found in Appendix A.

The OIG participates in several ongoing committee projects. Engagement in these activities results in increased knowledge of the system and allow for interaction of the OIG with state level stakeholders. There are currently several major ongoing activities that are participated in as follows:

Psychiatrists in Underserved Areas – This program, which is administered through joint participation of the Virginia Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Inspector General, is

designed to encourage psychiatrists to pursue practice in a rural or underserved area in Virginia. To date it has been very successful in placing 5 individuals, with an additional 3 persons scheduled to graduate during the 2004-2005 academic year. The program provides support through loan repayment and interaction with medical school training programs. A new coordinator for this program was hired during this six-month period.

Olmstead Accountability Committee - Dr. Everett served as a member of the task force and was an active participant in the accountability monitoring work group since the group began its work approximately a year ago. This committee was presented with the challenge of preparing a report that will serve as a guide to Virginia's plan for complying with the Olmstead Decision. The final report outlining the work of the committee was adopted during this reporting period. The report "One Community – Final Report of the Task Force to Develop an Olmstead Plan for Virginia" can be accessed on the website: www.olmsteadVA.com. The Olmstead decision asserts that under the Americans with Disabilities Act (ADA), the unnecessary institutionalization of persons with mental disabilities constitutes discrimination under certain conditions.

American Psychiatric Association Visions
Dr. Everett was invited by the President of the American Psychiatric Association to serve on the taskforce responsible for creating the Association's national vision for the mental health system. The report that resulted from the work of this nine-member taskforce includes twelve principles for guiding the mental health system. The report in its entirety can be found on the APA website.

D. DATA MONITORING

Critical Incident Reports

Critical incidents as defined by Virginia Code *§ 2.1-817* are sent to the OIG for review and monitoring. These incidents are those incidents occurring in one of the facilities that are serious enough to be associated with the resident or patient being evaluated by medical staff.

Approximately 689 critical incident (CI's) reports were reviewed within this semi-annual period. The OIG conducted an additional level of scrutiny and follow up for 185 of the 689 reviewed CI's. The information gathered from the additional inquiries was used to identify potential clinical problems with treatment of individuals within state facilities and to track trends in the facilities in areas such as falls risk. The information is often integrated into the inspections and schedule of the OIG.

Quantitative Data

In order to refine the inspection process so that core risks could be routinely monitored outside of the unannounced inspection process, a monthly facility report was instituted in January 2002. This report provides raw data on trends within facilities that might indicate a need for further clarification and possible onsite review. Areas that are monitored through this monthly report include but is not limited to: census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. The office has used this data to process 12 clarification requests during this six-month reporting period. The requests asked for amplification regarding significant data fluctuations over a period of time. All of the responses provided by the facilities were satisfactory to meet the needs of the office.

E. FOLLOW-UP REPORTING

All active or non-resolved findings from previous inspection reports are reviewed through a follow-up process until they have been successfully resolved. In general, evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include observations by the inspection team; interviews with staff and/or patients; or a review of policies and procedures, memoranda, medical records, meeting minutes, or other administrative and/or clinical documents.

Follow-up reviews of all active findings are completed at the time of the on-site snapshot inspection. This allows for more timely feedback to the facilities regarding progress towards satisfying agreed upon plans of correction. This consolidates travel and resources. DMHMRSAS currently provides comments in response to previous active recommendations simultaneously with the plan of correction regarding the snapshot inspection.

Follow-up reviews were conducted at the four facilities where snapshot inspections were completed. Follow-up reports were also completed during this reporting period for the Eastern State Hospital. This included findings from 14 reports and 58 findings, which had previously been active or unresolved during prior follow-up reviews. 22 findings were resolved or made inactive.

F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period a formal review has been completed of 4 DMHMRSAS Departmental Instructions, 3 State Board Policies, 1 DMHMRSAS

Survey Report on Workforce Issues, the current Discharge Protocols and the Draft 2004 Performance Contract.

DI 314(QM) – Guidelines for the Management of Patients with Multi-Drug Resistant Organisms
DI 313(QM) – Quality Services Committee
DI 512(HRM) – Leave Sharing Program
DI 201(RTS) – Reporting and Investigating Abuse and Neglect of Clients
State Board Policy 2011(ADM)88-3 – Naming of Building, Rooms and Other Areas at State Facilities
State Board Policy 3000(CO)74-10 – Employees Ineligible for Service on a CSB
State Board Policy 5008(FAC)87-12 – Accreditation/Certification

G. PRESENTATIONS AND CONFERENCES

During this reporting period presentations were provided for the following state and national groups and meetings associated with the mental health, mental retardation and substance abuse community:

American Psychiatric Association National Conference
MCV Grand Rounds on Statewide Suicide Prevention and Management
State Human Rights Committee
KOVAR Institute
DMHMRSAS State Board
The Regional Jail Advisory Committee in the Tidewater area
Presentations occurred with six chapters of NAMI-VA
New River Valley Local Human Rights Committee

H. MEETINGS

The OIG regularly participates in a variety of forums that address issues relevant to DMHMRSAS facilities and mental health issues.

DMHMRSAS Facility Directors' Meeting;
DMHMRSAS Facility Medical Directors' Meeting;
Mental Health Planning Council;
Virginia Association of Community Psychiatrists;
American Psychiatric Association Scientific meeting
American Psychiatric Association Assembly
Psychiatric Society of Virginia
Regular meetings with Virginia Office of Protection And Advocacy

Appendix A

SUMMARY OF OIG GOALS MEETINGS

The Office of the Inspector General completed six goals meetings with groups of consumers and advocates across the Commonwealth. The purpose of these meetings was to update consumers on the work of the Office and to provide them with an opportunity to share thoughts and experiences regarding the delivery of services within their respective regions. Two meetings occurred in the Northern Virginia area, two in the Tidewater area, one in Charlottesville, and one in the Southwestern Virginia region. Approximately 125 individuals participated in the discussions. The consumer and advocacy groups were very receptive to the opportunity to discuss both the strengths and limitations of the system. Those attending were knowledgeable and well informed. The groups spoke of the importance of being able to actively participate in the development of their treatment and recovery process.

Clubhouse programs and the growth of consumer-run services were identified as an effective method for communication among consumers regarding events, treatment options and the promotion of an increased sense of "community".

Although there were regional differences, several areas of common interest were shared by the groups throughout the State. Among these were the following:

- With the current increased focus on the process of restructuring the state-operated facility system and community based services, the consumer groups expressed concern regarding the availability of community inpatient beds for acute care admissions. Many spoke of the difficulties persons have in accessing acute care treatment in private facilities currently. The groups voiced fears that a decrease in the availability of beds in the state hospitals will diminish the ability of these individuals in accessing acute care when needed. An associated concern centered around the use of seclusion and restraint in community settings, which according to those present, has not been as effectively monitored to date as it has been in the state facilities. Consumers shared personal experiences of perceived violations of the rules and regulations governing the use of seclusion and restraint.

- The groups identified a need for either a change in the commitment process or the increased availability of community crisis stabilization services that could intervene earlier in the course of an illness relapse so that persons did not have to experience severe decompensation before treatment was initiated. This topic resulted in a discussion of the use of Advance Directives for mental health interventions. This would enable an individual and family a preference for how an illness is to be managed in the event of a relapse.

- The lack of affordable and safe housing was identified as a significant barrier in an individual's recovery process. Several persons shared the challenges associated

with finding stability within a community when the security of long-term affordable housing was not readily available. Several regions indicated that landlords were becoming increasingly reluctant to participate in the Section Eight housing program due to increasing regulations, which they are reportedly not subject to in other landlord-tenant agreements. The groups indicated that it is believed that an increasing number of persons are being discharged to settings such as homeless shelters. It was also indicated that individuals are hampered in obtaining accommodations in more independent settings as "rest homes" or adult homes are often the only available forms of housing. These settings are often problematic because the cost of living severely limits resources for the person to purchase personal items.

- The groups expressed concern that with the difficulties in accessing inpatient treatment, lack of crisis stabilization services and often the lack of stable housing options that jails have become the repository for persons with mental illness. The groups in the Tidewater area expressed being very concerned regarding the challenges of treating persons in the jails.

- Four of the six groups spoke of the need for increased accountability of the community services boards (CSBs) to consumers and advocates. It was suggested that CSBs needed to be required to demonstrate the efficacy of the services offered. Several consumers spoke of being on a waiting list for a therapist for a period of greater than a year. This was compounded by the lack of "freedom of choice" regarding accessing services within many of the CSBs. Others spoke of significant gaps in services, often periods of months, when their primary worker left the system before a replacement was hired and services reinitiated. The possibility of consolidating the CSBs into regional entities as a cost saving measure was raised as an issue for consideration.

The consumer groups offered a number of recommendations to the OIG for incorporation within the inspection process. It was recommended that inspections be conducted during the evening shift when patients/residents have more unstructured time. Several persons indicated that this shift was the most difficult because the professional staff had left for the day and limited opportunities for activities were available. It was suggested that by conducting an increased number of structured interviews with patients that the reports could provide additional information regarding the hospital experience from the perspective of those seeking treatment in that setting.

Other topics offered for consideration as future special projects included the cost of medications, which has become increasingly difficult for those with limited income; limited treatment within the jails; ways of balancing a persons desire to be employed without losing limited resources; and the needs of the dually diagnosed (MI/MR) population.

APPENDIX B

Inspection Reports Completed

This section contains the reports that were completed within this six-month period and approved for release by the Governor's Office. Each of the 5-released snapshot reports as well as the responses as submitted by DMHMRSAS is included in its entirety.

The one Secondary Report is not available because it contains information that is intended for peer review deliberation.

OIG Report # 79-03
SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
DANVILLE, VIRGINIA
DAVID LYON / FACILITY DIRECTOR

A Snapshot Inspection was conducted at Southern Virginia Mental Health Institute in Danville, Virginia on March 11-12, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas, which are consistent with basic rights as established under the Virginia Code. The areas are as follows: safe environment as manifested through the general conditions of the facility and staffing patterns, and, the active clinical treatment provided for patients.

Southern Virginia Mental Health Institute has undergone a number of administrative changes since the last inspection, including the hiring of a new facility director. Currently there is also an Acting Medical Director and the Clinical Director position has been changed to one of clinical facilitator. All of these positions were previously filled with individuals with extended (20+) years of service at the facility. The changes have provided SVMHI with an opportunity to review its current practices, identifying both strengths and areas for improvement within its service delivery system.

In negotiations with the DOJ for other facilities in Virginia, one registered nurse (RN) for each shift on each unit was a minimal requirement. This requirement is being meet at this facility despite on-going difficulties with the recruitment and retention of RNs.

Members of the OIG team observed active treatment programming throughout the inspection. SVMHI provides a variety of active treatment programs for patients based on their stability and level of functioning. The current configuration of programming is best suited for the acute care population. The facility recognizes the need to review programming options for longer care populations such as patients on NGRI status.

Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

PART I: STAFFING PATTERNS

1. Number of staff scheduled for this shift for this unit? DSA= Direct Service Assistant	**During the day shift:** **Unit E** 20 patients 3 DSAs, 3 RNs **Unit F** 20 patients 2 DSAs, 3.5 RNs **Unit G** 20 patients 4 DSAs, 3 RNs **Unit H** 20 patients 2.5 DSAs, 3 RNs
2. Number of staff present on the unit?	Direct Observation of unit staffing by OIG revealed that all staff were present as indicated above.
3. Number of staff doing overtime during this shift or scheduled to be held over?	Interviews with the Charge Nurse for each unit indicated that 1 person during the day shift was working overtime.
4. Number of staff not present due ab sence because of workman's compensation injury?	Interviews with the Charge Nurse for each unit indicated that 3 staff members were either out on workman's comp leave or assigned to light duty.
5. Number of staff members responsible for one-to-one coverage during this shift?	Review of staffing indicated that one unit had 1 person on 1:1 and that the staff on that unit rotated to comply with that requirement.

6. Are there other staff members present on the unit? If so, please list by positions?
Physicians, Psychiatrists, Social Workers, Activities Therapists and Psychologists visit each unit for a significant period of the day and were on site at the time of the inspection.

7. Additional comments regarding staff:

Southern Virginia Mental Health Institute has undergone a number of administrative changes since the last inspection, including the hiring of a new facility director. Currently there is also an Acting Medical Director and the Clinical Director position has been

changed to one of clinical facilitator. All of these positions were previously filled with individuals with extended experience (20+ years) at the facility. The changes have provided SVMHI with an opportunity to review its current practice, identifying both strengths and areas for improvement within its service delivery system.

It is of great concern that there are two locum tenans or temporary physicians currently at SVMHI. Physicians often play a critical clinical leadership role. Having two temporary psychiatrists in a facility of this small size is very unfortunate. This is also very expensive for a facility to maintain. Part of the reason for medical staff leaving includes an uncertainty as to the long-term future of this facility.

OIG Finding 1.1: The staffing observed at SVMHI is sufficient for the provision of safe supervision and treatment of individuals hospitalized at this facility.

OIG Recommendation: None.

DMHMRSAS Response: DMHMRSAS appreciates recognition by the Inspector General of SVMHI's efforts in maintaining appropriate staffing levels.

OIG Finding 1.2: Two of the five psychiatrist positions are currently occupied by temporary psychiatrists.

OIG Recommendation: OIG requests a written description outlining the strategies that will be used regarding recruitment for these two critical psychiatrist positions.

DMHMRSAS Response: SVMHI currently has acting Medical Director and four unit psychiatrists. Of the four unit psychiatrists, one is a P-14 (hourly) psychiatrist and one is a contract psychiatrist. SVMHI has been active in recruiting physicians. In May 2003, a full-time (P-3) psychiatrist will replace the P-14 (hourly) psychiatrist. At this time, SVMHI is conducting interviews that might result in replacing the contract psychiatrist with a full-time psychiatrist. If a suitable candidate is selected for hire, this psychiatrist will increase the number of full-time psychiatrists at SVMHI to five.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

At the time of the inspection, the census of all three shifts was as follows:

Capacity:	**Census:**
Unit E - 20	20
Unit F - 20	21 (1 on Special Hospitalization)
Unit G - 20	21 (1 on Special Hospitalization)
Unit H - 20	20

3. Number of patients/residents on special hospitalization status
Interviews with facility staff indicated that 2 patients were on special hospitalization status during this review; 1 for respiratory difficulties and 1 for the treatment of colon cancer.

4. Number of patients/residents on special precautions?
Interviews with facility staff indicated that six patients were on special precautions; 1 for aggressive behavior, 1 for cognitive difficulties, 2 for medical problems, and 2 for falling risk.

5. Number of patients/residents on 1 to 1?
Interviews with unit staff indicated that there was one patient during the visit that was on 1:1 status for aggressive behavior.

6. Identify the activities of the patients/residents?
Interviews with staff and patients, a review of facility policies regarding active programming and psychosocial rehabilitation program schedule indicated that a full complement of groups is offered throughout the day. The evening activities that are offered are primarily social including parties and dances. The next event planned is a St. Patrick's Day party. In addition, the Community Reintegration schedules off ground activities for those that have the appropriate privileges.

7. What scheduled activities are available for patients/residents during this shift?
The inspection took place during the day shift on Tuesday and Wednesday. During each of these days, 28 different groups were offered from 10:15 am – 4:15 pm for the 80 patients at the facility. Examples of groups are as follows: Symptom Management; Medication Management; Stress Management; Anger Management; Team Building; Understanding your Illness; Dealing with Cravings; Managing Panic and Anxiety; Communication Skills; Current Events; Community Living Skills; Social Skills; Money Management; Coping with Depressions and Values and Decisions.

8. Are smoke breaks posted?
Tours of the units and interviews with staff indicated that one of the four units displayed posted smoking times. Staff did indicate that all patients during orientation receive information on smoking times, which is whenever the Canteen is open.

9. Do patients/residents have opportunities for off-ground activities?
Interviews with staff indicated that depending upon the privilege level of the patient; there is opportunity for off ground activities. The facility has a Community Reintegration group that works with those that have earned off grounds privileges and meets on

Tuesdays to plan the activities and the completes the activities on Thursdays. Activities include going to the bank, restaurants, parks, bowling, and movies. A requirement to attend the Thursday activity is to be a part of the Tuesday planning meeting.

10. As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff and patients indicated that all patients get an evening snack and some, depending on diet or medical condition, are scheduled to receive a snack in the morning and afternoon. Patients can also purchase their own snacks in the Canteen.

11. Other comments regarding patient activities:
Clinical record reviews revealed linkages between initial assessments, barriers to discharge and treatment planning with each patient's involvement in active treatment programming. The current configuration of programming is best suited for the acute care population. The facility recognizes the need to review programming options for longer care populations such as patients on NGRI status.

OIG Finding 2.1: SVMHI provides a variety of active treatment programs for the patients based on their stability and level of functioning.

OIG Recommendation: Review options for developing alternate programming for individuals on NGRI status, who could benefit from increased exposure to both educational and employment rehabilitation programs.

DMHMRSAS Response: SVMHI uses a Psychosocial Rehabilitation Model in the treatment of its hospitalized consumers. The Director of Psychology, who is a Ph.D. level psychologist and a Board Certified Forensic Psychologist of the American Academy of Forensic Psychologists, is heading up a Performance Improvement Project Team to address treatment programming for clients with NGRI status. The charge of this team is to embrace the principles of Psychosocial Rehabilitation in designing programming that is beneficial for individuals on NGRI status.

PART III: INSPECTION OF THE ENVIRONMENT

AREA OF REVIEW: Common Areas	**Comments and Observations**
1. The common areas are clean and well maintained.	Tours of all common areas of this facility confirmed that each area was clean, essentially free of odors and well maintained.
2. Furniture is adequate to meet the needs and number of	Tours of each unit indicated that furniture in common areas was adequate to meet the needs and numbers of patients on each unit.

patients/residents.	
3. Furniture is maintained and free from tears.	Tours of each residential area indicated that furniture was free from tears and is well maintained.
4. Curtains are provided when privacy is an issue.	Tours of residential units demonstrated that window coverings are provided for privacy from the outside.
5. Clocks are available and time is accurate.	Tours of all four units indicated that clocks were available in public areas and had the correct time.
6. Notification on contacting the human rights advocate is posted.	A poster, providing information on how to contact the Human Rights Advocate, is posted in a public area of each unit.
7. There is evidence that the facility is working towards creating a more home-like setting.	There is evidence that the facility is working to create a more homelike atmosphere. The day rooms are nicely decorated with many faux plants, lots of windows, an entertainment center with a TV and books, games and pictures. In the intersections of the hallways, there are wall murals, large boxes with faux plants and large leafy trees.
8. Temperatures are seasonally appropriate.	Tours of each unit during all three shifts confirmed that temperatures were seasonally appropriate even though one day of the inspection it was sleeting and the second day of the inspection it was warm and sunny.
9. Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours of visiting area and observations of family's visiting with clients indicated that the areas designed as visiting areas were set up appropriately.
10. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature. There is a well-stocked library. Patients are allowed to make one phone call per shift. There are pay telephones if additional phone calls are desired.
11. Hallways and doors are not blocked or cluttered.	Tours of units indicated that hallways and doors are not blocked and cluttered.

12. Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
13. Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff and patients indicated that fire drills are conducted once per shift per month and patients were aware of where of proper procedures.
14. Fire drills are conducted routinely and across shifts.	Interviews with staff indicated that fire drills are conducted once per shift per quarter.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well maintained.	Tours of all residential units indicated that all bedrooms overall were clean and well maintained. Staff indicated that with the elimination of the token store there is not as much motivation to keep a room clean for some patients.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of bedrooms on all units indicated that each patient is furnished with a mattress, sheets, blankets and a pillow. If there is a need for an egg-crate mattress topper, it can be requested through a physician.
3. Curtains or other coverings are provided for privacy.	Tours of all residential units confirmed that curtains and other coverings are provided for patient's privacy.
4. Bedrooms are free of hazards such as dangling blind chords, etc.	Tours indicated that there are no blinds in bedrooms; curtains are used as the window coverings.
5. Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients are given the opportunity to personalize their rooms. Staff will work with patients in Arts and Crafts groups to construct safe decorations.

Seclusion Rooms	Comments and Observations
1. Seclusion and/or time out rooms are clean.	Tours and observations indicated that seclusion and/or time out rooms were clean.
2. Seclusion and/or time out rooms allow for constant observations.	Tours of units indicated that seclusion and/or time out rooms do allow for constant observation.
3. Bathrooms are located close to the seclusion or time-out areas.	Tours of units indicated that seclusion and/or time out rooms are located next to the time out bathrooms.
Bathrooms	**Comments and Observations**
1. Bathrooms were clean and well maintained	Tours of unit bathrooms indicated that all were cleaned and well maintained.
2. Bathrooms were noted to be odor free.	Tours of unit bathrooms across all shifts indicated that all were odor free.
3. Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
2. Buildings are identified and visitor procedures for entry posted.	Upon entering the hospital all visitors are required to check in, receive a visitors badge and be escorted to their location.
3. Grounds are maintained.	A driving tour of the grounds demonstrated that all are well maintained.
4. There are designated smoking areas with times posted.	The designated location for smoking is the Canteen and patio and the times are noted.

5. Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients regularly go outside on and off grounds, weather permitting.

Other comments regarding the environment:
Southern Virginia Mental Health Institute is in the process of completing a total renovation of the fire alarm system. This project has been a goal for the past five years.

OIG Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

OIG Recommendation: None.

DMHMRSAS Response: DMHMRSAS appreciates recognition by the Inspector General of the maintenance of the SVMHI environment.

PART FOUR: APPLICATION OF PRINCIPLES OF BEHAVIORAL MANAGEMENT

Interviews were conducted with administrative and clinical staff regarding the use of behavioral management within the facility. In addition, an active plan as well as policies and procedures governing behavioral management were reviewed.

Referrals are made to the Director of Psychology when the treatment team determines that a formalized behavioral plan is clinically indicated. The Director works with the team psychologist on completing a functional analysis of the target behavior and developing a behavioral support plan for addressing the identified behavior, including positive reinforcers. The Behavioral Management Committee oversees behavioral support plans. This seven-person committee includes members of the clinical leadership within the hospital, such as the Medical Director and the Director of Nursing. The Local Human Rights Committee reviews behavioral plans that have restrictive components.

Staff responsible for implementing the plans are provided with extensive training, usually by the team psychologist, throughout the duration of the plan. At the time of the inspection, there was one patient on a behavioral support plan. In addition, members of the psychology department conduct annual training with the staff concerning principles of behavioral management.

Behavioral management programming, which is used on all the units, is designed to create new conditions for learning and eliminate or reduce undesired behaviors for all patients. There are many techniques for the development of a unit behavioral management system including daily community meetings, the formation of unit rules and

for some patients the use of a token economy, for the provision of rewards for the successful completion of specific target behaviors.

In addition to general behavioral strategies, treatment teams in cooperation with unit direct care staff develop informal behavioral strategies for use as brief interventions when the team wants to increase the strengthening of target behaviors through the development of person specific reinforcements. Target behaviors might include increased attention to ADLs, attending active treatment programming or maintaining personal space. These strategies are often a key element in assisting the patient in adapting to the environment and promoting behaviors consistent with recovery goals.

Even though behavioral management support plans have been developed and serve as a useful tool in the clinical management of challenging patients, the discontinuation of the token store has severely limited options for applying behavioral management principles as a part of unit management. Members of the OIG team observed that bedrooms within the facility were significantly messier than during previous inspections. Staff indicated that since the closing of the token store, there are few incentives for engaging patients in performing activities of daily living, maintaining their personal space and attending groups.

There is a cost benefit in engaging patients early on in hospitalization that may reduce length of stay and promote habits and skills, which result in better community adaptation. Providing tangible incentives for positive behaviors while in an inpatient setting can be an important first step in promoting healthy and sustained recovery.

Members of the Psychology Department, which includes 3 Master's level and two PhD level psychologists, have all completed the formalized behavioral management training.

OIG Finding 4.1: SVMHI utilizes informal behavioral management programming throughout the facility and develops individualized behavioral management plans for those with specialized or unusually intensive needs. The capacity to maintain a viable and constructive facility behavioral management program has been severely limited by the closing of the token store. This was done due to budget reductions.

OIG Recommendation: Work with Central Office in determining ways to re-open the token store.

DMHMRSAS Response: The SVMHI token store, as noted, was discontinued due to funding reductions. SVMHI recognizes that the loss of this tool may have impacted our behavioral management program. SVMHI continually monitors its behavioral management program and, as part of this monitoring effort, will consider the viability of reinstating the token store during the next fiscal year. Discussions with the Division of

Facility Management will ensue should the decision to re-open the store be made and new funding be required.

OIG Report # 80-03
EASTERN STATE HOSPITAL
WILLIAMSBURG, VIRGINIA
JOHN FAVRET / FACILITY DIRECTOR

A Snapshot Inspection was conducted at Eastern State Hospital in Williamsburg, Virginia during March 17-19, 2003. The purpose of a snapshot inspection is to conduct an unannounced inspection pursuant to VA Code: 37.1-256.1.G which specifies that the Inspector General must report on *general conditions, staffing patterns and access to active and contemporary treatment*, at each facility no less than once a year. Additionally, a number of elements from the Quality Improvement Plan agreed upon between The Commonwealth of Virginia and the Department of Justice (DOJ) were reviewed.

Regarding general conditions of the treatment and living spaces at ESH, observations of the facility revealed that the hospital was clean and well maintained. ESH is very institutional in appearance overall which reflects an emphasis on the value of military orderliness that was in vogue at the time of the original construction of these units. At the time of the inspection, most units were uncomfortably warm due to the inflexibility of the institutional heating system to accommodate to spring time variations in temperature.

Regarding active treatment, active treatment programming was observed throughout each section of the facility. At least one of the programs scheduled for the Geriatric units did not occur as scheduled. Concerns about this have been noted on previous OIG visits. (OIG Report 53 conducted in 2002.)

Regarding staffing, ESH in general has had a difficult time in maintaining adequate staffing without use of extensive overtime. There are three nursing staffing elements in the ESH Continuous Quality Improvement Plan that was created in 1996 in response to Department of Justice concerns. Although some sections of ESH meet these requirements, there is not consistent facility wide ability to uniformly sustain these levels of staffing, even with the extensive utilization of overtime. There have been ongoing difficulties with recruitment and retention of RN staff. At the time of the inspection there were approximately 50 RN staff vacancies. Many of the staff are extremely dedicated public servants who work overtime at ESH as opposed to second jobs at other entities wherein they might earn higher wages due to dedication to the patient served by ESH as well as stable state benefits. The ongoing uncertainty about the future of ESH has contributed to the difficulty in recruiting and retaining new staff. OIG reports have raised concern about this since 2000. (OIG Report 31 conducted in 2000).

Regarding adherence to the ESH Continuous Quality Improvement Plan, there is clear ongoing effort to maintain the core elements of this plan. Many of the elements within this plan have become an established and routine part of treatment and care. These elements include but are not limited to: multidisciplinary treatment and medication treatment planning, physician and professional staffing, provision of contemporary active treatment, pharmacy monitoring and clinical documentation. At this time, the area of greatest concern at this facility is the nursing overtime that is utilized to approximate the safe staffing level set forth in the ESH Continuous Quality Improvement Plan.

PART I: STAFFING ISSUES

1. Number of staff scheduled for this shift for this unit. DSA= Direct Service Assistant	**March 17 – Day Shift** Building 24 – Long Term Adult Unit B – 20 Patients 1 RN, 1 LPN, 3 DSA's Unit C – 23 Patients 1 RN, 1 LPN, 3 DSA's Unit D – 24 Patients 1 RN, 4 DSA's Building 25 – Long Term Adult Unit A – 20 Patients 1 RN, 1 LPN, 4 DSA's Unit B – 20 Patients 2 RN's, 1 LPN, 3 DSA's Unit C – 22 Patients 1 RN, 5 DSA's Building 26 – Long Term Adult Unit B – 24 Patients 1 RN, 1 LPN, 4 DSA's Unit C – 24 Patients 1 RN, 5 DSA's Unit D – 24 Patients 1 RN, 1 LPN, 3 DSA's **March 17 – Evening Shift** Building 2 - Admissions Unit A-1 – 14 Patients .5 RN, .5 LPN, 3 DSA's Unit B-1 – 17 Patients 1 RN, 1 LPN, 3 DSA's Unit C-1 – 11 Patients 1 RN, .5 LPN, 2 DSA's Unit A-2 – 11 Patients 1 RN, .5 LPN, 4 DSA's Unit B-2 – 15 Patients 1 RN, .5 LPN, 4 DSA's Unit C-2 – 15 Patients 1 RN, 3 DSA's

	March 17 – Night Shift Building 34 – Hancock Center Unit A – 16 Patients .5 RN, 1 LPN, 2 DSA's Unit B – 17 Patients . 5 RN, 1 LPN, 2 DSA's Unit C – 18 Patients 1 RN, 3 DSA's **March 18 – Day Shift** Building 34 – Hancock Center Unit A – 16 Patients 2 RN's, 4 DSA's Unit B – 17 Patients 1 RN, 1 LPN, 3 DSA's Unit C – 19 Patients 1 RN, 1 LPN, 4 DSA's Building 4 - Medical Center Unit A – 10 Patients 1 RN, 2 LPN's, 1 DSA Unit B – 8 Patients 1 RN, 1 LPN, 2 DSA's Unit D – 7 Patients 1 RN, 1 LPN, 2 DSA's
2. Number of staff present on the unit?	Observations of unit staffing revealed that staffing was present as indicated above.
3. Number of staff doing overtime during this shift or scheduled to be held over?	Three staff were reported to be working overtime for a shared total of 16 hours.
4. Number of staff not present due absence because of workman's compensation injury?	Interviews with facility staff during the inspection of all shifts on the units listed above indicated that 5 staff members were out on Workman's Compensation leave and one was assigned to light duty.
5. Number of staff members responsible for one-to-one coverage during this shift?	Interviews with facility staff indicated that during the inspection of the three shifts on the units listed above indicated that 6 staff were responsible for a 1:1 coverage.

6. Are there other staff members present on the unit? If so, please list by positions? During the inspection on the day shift Physicians, Social Workers and Activities Therapists were noted in the Hancock Center Buildings; Physicians were noted in the Medical Center and on the Admissions Units.

7. Additional comments regarding staff: Staff were less verbal regarding concerns related to the use of pressure to work overtime than in past inspections. Even though there is still a significant use of overtime at this facility, there has been an emphasis on the liberalizing the use of voluntary overtime so that individuals desiring overtime, and who otherwise might take on a second job elsewhere, are able to work extra hours at ESH. Several staff from different units relayed that this has resulted in an increase in morale.

At the time of the inspection there were approximately 50 RN vacant positions at ESH.

The ongoing use of overtime is a potential serious problem at ESH. Over the last year the OIG has monitored nursing staff overtime on a monthly basis in each of the fifteen facilities operated by Virginia. Each facility is within a different area and faces different local economies. However, of the mental health facilities, ESH by far has the greatest sustained use of professional nursing and direct care overtime as reported through this monthly report. The use of overtime at ESH is greater per patient in comparison with 7 other similar mental health facilities operated by the commonwealth of Virginia. For January and February of 2003, based on reports submitted from each facility to OIG, ESH used an average of 23.5 hours of overtime in RN, LPN and Direct Care staff for each patient. The average use per patient for the same two months in other DMHMRSAS mental health facilities for January and February 2003 ranged from 14.4 to .81 hours of overtime per patient for these first two months in 2003. (Note: the comparison facilities and average hours of nursing and direct care staff overtime per patient for the first two months of 2003 were: **ESH 23.5,** CSH 14.4, SVMHI 9.2, WSH 7.9, Catawba 7.02, NVMHI 6.95, Piedmont Geriatric 6.23, and SWVMHI .81. These numbers were calculated by adding the total hours of reported overtime per month for RN, LPN and Direct Care staff. This number was then divided by the facility census at the beginning of each month. Clinical staff overtime hours per patient were then averaged over these two months to result in the numbers as reported above.)

With regards to nursing and direct care staffing, there are three components that are set forth as goals for nursing staffing. These are clearly established in the ESH Continuous Quality Improvement Plan as negotiated with the Department of Justice in 1996. In general these goals are: 1. The percentage of RN staff for each ward should be 20 to 30%; 2. The number of hours per patient day should be about 5 to 5.5; and 3. There should be one RN per shift for virtually each clinical unit providing care to mentally ill persons.

The February 2003 nursing staffing report maintained by ESH which tracks compliance with the agreed upon staffing goals was reviewed. There are times at ESH when the goal

of having one RN present on each shift on each unit is not met. Primarily this occurs on third or night shift in the geriatric and the admissions units. The units most likely to be low in terms of proportion of RN in the total staffing pattern are the six admissions units. The goal to have 25-30 percent of all nursing staffing be RN level staff, and in February the proportion of RN staff was only 17%.

The current process of a regional Reinvestment Plan serves to compound the already difficult staffing situation at ESH. At the time of this inspection, staff on all levels voiced concern regarding the projected lay-offs of personnel as the facility moves towards the proposed closing of the acute admissions building. Administrative staff indicated that the plans are to place as many staff as possible in existing vacancies in other units within the facility, however as of the time of this inspection, administrative and clinical staff were not aware of details regarding how the currently proposed restructuring of public mental health care in this region would effect staffing needs at ESH. Several staff are or are considering pursuit of employment alternatives due to concerns about perceived instability of ESH. Several staff expressed disinterest in working with long-term or geriatric patients and would leave ESH as opposed to working in geriatric or long-term units. This is in contrast to staff at other Virginia facilities that are very positively inclined toward work with long term and geriatric patients. This may reflect a difference in facility culture.

Tours of units in the Admissions Building (#2) determined that seclusion and/or time out rooms do allow for constant observation. When OIG staff asked unit staff while touring the admissions unit, what their policy and practice for seclusion was, 4 out of 6 units indicated that a staff member sat outside of the room the entire time and viewed the patient through the window every 15 minutes. OIG staff observed this practice while onsite. DI 211 "Use of Seclusion and Restraint" provides direction that persons in seclusion are to be continuously monitored and that this can be accomplished through having a staff person sit outside a seclusion room. While this does provide for a person to be monitored, this does allow for an unstable patient to be out of the direct line of sight of a staff person. Many hospitals reduce the potential risk of harm to resident while in seclusion through the use of video monitoring which enables less intrusive (i.e. there is not the face of a staff looking through a window, but allows for continuous visual monitoring.

Finding 1.1 Clinical staff overtime at ESH is disproportionately high.

Recommendation: Overtime staffing is a critical problem that places the quality of care at risk within this facility. In addition to ongoing internal efforts to maintain staffing, the deployment, availability, and professional development of clinical staff should be a central consideration in the reinvestment effort currently underway.

DMHMRSAS Response: The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community

colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses, and this has been received positively. ESH will continue to make every effort to hire sufficient nurses to meet the required HPPD. Providing a safe environment for the patients and staff is the priority for ESH; and this will continue to requires overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible. Although the results of the proposed reinvestment initiative will not be known until after the initiative has been fully implemented, it is hoped that the RNs from the proposed program closures will improve the RN staffing ratio in other programs.

Finding 1.2. Recruitment and retention difficulties for nursing positions continue to result in this facility operating with less than RN per unit per shift.

OIG Recommendation: Continue to work toward the goal of one RN per unit per shift for all shifts and units.

DMHMRSAS Response: See response to Finding 1.2 above.

Finding 1.3: There is destabilizing uncertainty regarding possible lay-offs within the facility as a result of budget reductions as well as the proposed restructuring of the acute admissions unit.

OIG Recommendation: Central Office staff and others involved with planning for the impending restructuring of acute care at ESH provide as much specific information regarding plans with projected timeline implementation to clinical staff and consumers at ESH.

DMHMRSAS Response: Central Office and ESH staff are working with the planning committees to address these important issues pertaining to “reinvestment” of acute admission care to the community. Information on specific plans and timelines will be announced to ESH staff as the planning authorities develop them.

Finding 1.4: During the tour in Building 2, patients in seclusion were not under constant direct visual observation.

OIG Recommendation: Consider the institution of video monitoring equipment, which would allow for the capacity to continuously directly observe individuals in seclusion.

DMHMRSAS Response: ESH policy number TX450-35, "Emergency Use of Seclusion or Restraint", states that a patient who is in seclusion must be under constant observation. Further staff in-services on the policy will be given with an emphasis on those staff and supervisors working in Building 2. New computer software for monitoring seclusion and restraint will be initiated in July, and this software will help monitor adherence to the policy. The ESH Administrative and Clinical Leadership will review the feasibility of instituting a video monitoring system for continuous observation of secluded individuals in Building 2. In addition, a system-wide initiative to decrease seclusion and restraint usage will be piloted this fall.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

During the review, the census of all three shifts was found to be:

Capacity:	**Census:**
Building 24 (Long Term)	
Unit B – 22 Beds	20 Patients
Unit C – 23 Beds	23 Patients
Unit D – 24 Beds	24 Patients
Building 25 (Long Term)	
Unit A – 19 beds (1 Cot)	20 Patients
Unit B – 19 Beds (1 Cot)	20 Patients
Unit C – 19 Beds (3 Cots)	22 Patients
Building 26 (Long Term)	
Unit B – 24 Beds	24 Patients
Unit C – 24 Beds	24 Patients
Unit D – 24 Beds	24 Patients
Building 2 (Admissions)	
Unit A-1 – 14 Beds	14 Patients
Unit B-1 – 18 Beds	17 Patients
Unit C-1 – 16 Beds	11 Patients
Unit B-2 – 18 Beds	15 Patients
Unit C-2 – 18 Beds	15 Patients

Capacity:	**Census:**
Building 34 (Geriatric)	
Unit A – 20 Beds	16 Patients
Unit B – 20 Beds	17 Patients
Unit C – 20 Beds	19 Patients

Building 4 (Medically Complex)

Unit A – 25 Beds	10 Patients
Unit B – 25 Beds	8 Patients
Unit D – 25 Beds	7 Patients

3. Number of patients/residents on special hospitalization status
Interviews with staff indicated that during the inspection period, four patients were on special hospitalization status either in the Medical Center on grounds or at Williamsburg Community Hospital.

4. Number of patients/residents on special precautions?
Interviews with staff on units inspected indicated that 101 patients were noted to have a special precaution addressing issues for falls (40), choking (55), seizure (1), diabetes (3), or contact (2).

5. Number of patients/residents on 1 to 1?
Interviews with staff on units inspected indicated that 6 patients within the facility during the time of the inspection were on 1:1 coverage either during activities, for safety precautions or due to self-injurious behavior.

6. Identify the activities of the patients/residents?
During the day and evening shift the OIG staff toured residential and treatment areas and observed activities that were conducted. Activities of patients differed depending on skill level. Long Term Adult Patients leave their buildings to attend day treatment in either the Davis Building or Building 12**.** The selections of activities that are offered are listed in the next section.

Geri-Active Program – GAP: The activities offered for the Geriatric population are provided in the Hancock Center, which is a group of 4 buildings, (3 of which are residential). The Program for the Geriatric population is the Geri –Active Program (GAP). The GAP is primarily targeted for higher functioning individuals and is offered from 9:30– 11:30am on weekdays. The morning is split into two sections in which patients that are in the program leave their wards for activities in other buildings or other units.

The broad goal for this program is to enhance skill sets for the patients as well as to prevent the loss of an individual's current level of functioning. The two sessions of the GAP program were completed as scheduled. Those that did not participate in the Gap program had other programs scheduled throughout the day, with two to three 30 to 45 min activities scheduled.

Other programming options for the geriatric population in Building 34:
Observations of Building 34 activities demonstrated that many staff did not understand the daily schedule of the overall program. When asked, staff had a hard time answering

questions abut the daily schedule and the content of activities. In addition all wards in Building 34 did not offer programming throughout the day.

On one of the days of the inspection, A Ward had two activities scheduled, Worship, scheduled in the morning for 30 minutes; and Recreation Therapy, scheduled in the afternoon for 45 min. The Worship activity did not occur, because the facilitator did not show up, but the afternoon Recreational Therapy did occur for 45minutes.

B ward had three activities scheduled, Worship, Dance Therapy and a Van Ride (for those that had off ground privileges). All three activities occurred as scheduled.

C ward had a movie in the morning, which was part a staff conducted activity designed for social interaction activity, In addition, Dance Therapy occurred as was scheduled in the afternoon.

During the times there were no activities offered, patients sat and watched TV, slept or were in bed. Occasionally there was someone walking through the unit or listening to the radio, but for the most part, without a scheduled activity, patients sat. During scheduled activities, patients participated with the group or independently. The best example was on C ward when the Dance Therapist turned off the TV and turned on some music (Motown), many patients started to move on their own. Though the Dance Therapist was there to work with just three of the patients, some of the others were inspired to dance on their own.

Observations of the activities conducted during the day in building 34 clearly indicated that patients responded during the activities conducted as opposed to the times when there no activities and most just sat with the TV on and watched or slept.

Building 12 Psychosocial Rehabilitation Programming:
A member of the inspection team observed several groups offered in Building 12. The psychosocial rehabilitation programming that occurs in this setting is designed to meet the active treatment needs for the chronic care population who are more likely to benefit from increased supervision. Group content and session lengths are appropriately modified in order to take into consideration the stability, level of functioning and cognitive ability of the patients. The discharge planning group uses modules to highlight issues important to successful re-entry into the community such as medication and symptom management. The facilitator engaged the patients in a discussion, which was paired with written materials for further review

A tour was conducted of the Community Awareness Program (CAP). This day treatment program provides structured activities for individuals with more persistent negative symptoms that can diminish a person’s ability to successfully interact in life and with other people. The program engages each person in a variety of activities that supports socialization and other skills that can sustain the person’s efforts towards community re-integration.

7. What scheduled activities are available for patients/residents during this shift?
Inspection tours indicated that most scheduled activities occur between 9:30 am and 3:00 pm. The activities are scheduled and patients are assigned based on treatment needs. The two main sets of activities scheduled are in the Hancock Center for the Geriatric population and the Brown Building for the Long Term Adult population. The GAP activities scheduled in the Hancock Center that were observed by OIG staff included the following: Community Integration; Grounds Crew; Music Group; Yoga Health and Mobility; Chair Exercises; Social Time; Relaxation Group; Holiday Celebrations; Bell Choir; Health & Nature; Fitness; Worship; Leisure Fun; Let's Talk; Games; Dance Therapy; Story Time; Directive Group; Poetry and Prose; Pet Visits; Van Ride; Bingo; Canteen; Easy Listening.

The activities scheduled for the Long Term Adult population included: Music; Sensory Stimulation; Music Movement; Music Therapy; Library; Emotional Awareness; Exercise/Walk; Grounds Crew; Horticulture; Juggling Life for Satisfaction; Life Skills; Symptom Management; Woodshop; Art Therapy; Arts& Crafts; Community Awareness; Health Issues; Boosting your Self Esteem; Recovery Pathwork; Swim Lesson Group; NGRI Group; Housekeeping; Basic Education; Cognitive Awareness Program; Community Re-Entry; Problem Solving; .Mental Health Issues; Positive Image; Substance Abuse Education and Life Skills.

8. Are smoke breaks posted?
Tours of units indicated that the majority of units had smoke breaks posted.

9. Do patients/residents have opportunities for off-ground activities?
Facility staff indicated to inspection staff that off ground activities are determined based on the privilege that a patient has been assigned. For those with the appropriate privileges, van rides, special events trips, trips to promote community interaction including to a restaurant or store occur weekly.

10. As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur in the morning and evening and through out the day as appropriate. Special dietary needs and preferences are able to be accommodated.

11. Other comments regarding patient activities: None

OIG Finding 2.1: Eastern State Hospital provides a variety of psychosocial rehabilitation programs.

OIG Recommendation: None.

DMHMRSAS Response: Concur

OIG Finding 2.2: Staff interviewed in Building 34 were not able to accurately identify whether active treatment programs were available for patient participation. At least one activity program that was scheduled did not occur.

OIG Recommendation: continue with the goal or providing quality active treatment programs that promote healthy recovery for individual patients.

DMHMRSAS Response: Concur. The ESH Clinical Leadership Team in geriatrics and specifically the RNC assigned to Building 34 and the OT Supervisor will redistribute the revised definition of Active Treatment to all geriatric staff, particularly those staff assigned to Building 34. This will include re-educating the staff to increase their understanding of the active treatment process, their role in those treatment/care activities, and their ability to articulate the daily schedule for patients' health and well-being.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
1. The common areas are clean and well maintained.	Tours of all common and residential areas of units inspected confirmed that each area was clean, essentially free of odors and well maintained.
2. Furniture is adequate to meet the needs and number of patients/residents.	Tours of each unit indicated that furniture, in common areas, was adequate to meet the needs and numbers of patients on each unit.
3. Furniture is maintained and free from tears.	Tours of each residential area indicated that furniture was free from tears and is well maintained.
4. Curtains are provided when privacy is an issue.	Tours of residential units demonstrated that window coverings are provided for privacy from the outside. In addition, for those geriatric patients in the open wards, curtains are provided around beds for privacy.
5. Clocks are available and time is accurate.	Tours of all 19 units indicated that clocks were available in public areas and had the correct time.
6. Notification on contacting the human rights advocate are posted.	Tours of each unit indicated that a poster providing information on how to contact the Human Rights Advocate is posted in a public area of each unit.

7. There is evidence that the facility is working towards creating a more home-like setting.	Tours of 19 of the residential units at the facility indicated that the facility was working towards a more homelike atmosphere as appropriate for the population. Each residential unit had different homelike aspects. There areas decorated with stenciling, faux plants, upholstered furniture, pictures, quilts and stuffed animals. Some units had large arched windows decorated with valences and pictures on the wall. All areas had a TV and books and music available for clients.
8. Temperatures are seasonally appropriate.	Tours of units during all three shifts confirmed that temperatures were warm outside and especially warm inside. When asked staff commented that buildings and grounds respond in a timely fashion to make adjustments to the thermostats. Most staff indicated that the old heating and cooling systems often result in uncomfortable temperatures during seasonal transitions.
9. Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours of visiting areas and observations of family's visiting with patients indicated that the areas designed as visiting areas were set up well.
10. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature. There is a phone in each dayroom that can be used for local calls. Long distance calls are arranged through the Social Worker. Writing materials are available and provided by staff upon request and the facility will stamp and mail all items.
11. Hallways and doors are not blocked or cluttered.	Tours of units indicated that hallways and doors are not blocked and cluttered.
12. Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
13. Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff and patients indicated that fire drills are conducted once per shift per month and patients were aware of where to go for safe egress. For those buildings that have medically fragile residents, Staff indicated that fire alarms are tested weekly and staff are quizzed on appropriate evacuation procedures, instead of

	evacuating patients from the building every month.
14. Fire drills are conducted routinely and across shifts.	Interviews with staff and patients indicated that fire drills are conducted once per shift per month and patients were aware of where to go. For those buildings that have medically fragile residents, Staff indicated that fire alarms are tested weekly and staff are quizzed on appropriate evacuation procedures, instead of evacuating patients from the building every month.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well-maintained.	Tours of 19 residential units indicated that all bedrooms overall were clean and well maintained.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of bedrooms on the 19 units indicated that each client is furnished with a mattress, sheets, blankets and a pillow. If there is a need for additional items there are linen closets on each unit or in each building.
3. Curtains or other coverings are provided for privacy.	Tours of the residential units confirmed that curtains and other coverings are provided for clients privacy. In the adult long term care units the blinds are located inside the window panes, in the units for geriatric patients, curtains are provided on windows and around beds for privacy.
4. Bedrooms are free of hazards such as dangling blind chords, etc.	The residential areas toured were free from hazards.
5. Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients are given the opportunity to personalize their rooms.

Seclusion Rooms	Comments and Observations
1. Seclusion and/or time out rooms are clean.	Tours and observations indicated that seclusion and/or time out rooms were clean, except for some located in the Admissions building, which had brown dripping stains on the ceilings.
2. Seclusion and/or time out rooms allow for constant observations.	Tours of units indicated that seclusion and/or time out rooms do allow for constant observation. When OIG staff asked unit staff while touring the admissions unit, what their policy and practice for seclusion was, 4 out of 6 units indicated that a staff member sat outside of the room the entire time and viewed the patient through the window every 15 minutes.
3. Bathrooms are located close to the seclusion or time-out areas.	Tours of units indicated that seclusion and/or time out rooms are located next to the time out bathrooms.
Bathrooms	**Comments and Observations**
1. Bathrooms were clean and well maintained	Tours of unit bathrooms indicated that all were cleaned and well maintained.
2. Bathrooms were noted to be odor free.	Tours of unit bathrooms across all shifts indicated that all were odor free.
3. Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well-lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
2. Buildings are identified and visitor procedures for entry posted.	Upon entering the hospital all visitors are required to check in, receive a visitors badge and be escorted to their location.
3. Grounds are maintained.	A driving tour of the grounds confirmed that they were well maintained.

4. There are designated smoking areas with times posted.	A tour noted that there are designated areas for smoking.
5. Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients with the appropriate privileges regularly go outside on and off grounds, weather permitting.

Other comments regarding the environment: One of the program rooms in Building 12 had brightly colored balls hanging from "fishing wire". The balls appeared to be glass. Both the balls and the wire can present a risk to patients. Staff indicated that the decorations are positioned so as to minimize risk. It was also maintained that patients are never in the rooms unaccompanied by staff.

Eastern State also has constructed a therapeutic labyrinth on the grounds in order to provide both the staff and the patients with this additional restorative environment.

OIG Finding 3.1: Tours of 19 units revealed the facility overall was generally clean and well maintained.

OIG Recommendation: None.

DHMRSAS Response: Concur. ESH Housekeeping Services takes pride in maintaining the cleanliness of all facilities.

OIG Finding 3.2: The temperature in a majority of the units toured was uncomfortably warm throughout this inspection.

OIG Recommendation: None.

DMHMRSAS Response: Due to the nature of commercial heating and cooling systems, temperatures will vary greatly during the transitional seasons of Spring and Fall. Air conditioning is usually turned on for the season on May 1st of each year.

OIG Finding 3.3: An activity room in Building 12 had glass ornaments and nylon wire as a part of the decorations which were very attractive but could pose safety risks.

OIG Recommendation: Facility risk management may want to review the risks Vs benefits in using these particular objects as decorations.

DMHMRSAS Response: The Department appreciates the recognition of the attempts by ESH to improve the appearance of the facility. The ornaments referred to in the OIG report were plastic, not glass and as such did not pose as great a safety risk as was thought. The lengths of nylon wire on the paper decorations hanging from the ceiling

were checked and were found to be less than 10 inches in length. These were hanging from the ceiling at a height where an average height person would require a chair or ladder to remove them. The facility further shortened the lengths of nylon used to hang the ornaments.

In addition, patients are never allowed in the art room without staff. Seasonal decorations will continue to be evaluated to avoid any possible hazard to patients or staff.

PART IV: COMPLIANCE WITH SELECTED PORTIONS OF THE ESH CONTINUOUS QUALITY IMPROVEMENT PLAN

Eastern State Hospital was one of five facilities within Virginia that was sued by the federal government through the Department of Justice for violations under the Civil Rights of Institutionalized Persons Act (CRIPA). CRIPA provides that persons in state operated institutions have a right to receive active treatment in a safe environment. A plan for continuous quality improvement was agreed upon between these parties. This agreement outlined a number of details. The execution of this plan resulted in a major reorganization of virtually all clinical services within ESH. In 1999 the final tour of ESH by the Department of Justice was completed. At this time DOJ determined that ESH had implemented the ESH Continuous Quality Improvement Plan as agreed upon between the Commonwealth of Virginia and the Department of Justice.

With this particular OIG inspection, in addition to the basic components of the required annual inspection of conditions, staffing and access to active treatment, several basic components of the ESH Continuous Quality Improvement Plan (ESH CQIP) were reviewed to determine the current status of the ongoing implementation of this plan. The ESH CQIP was originally created seven years ago, in 1996.

A. General Medical Care:

1. Physician Staffing

Eastern State Hospital maintains a compliment of 19 psychiatrists and seven medical care physicians. The number of physicians currently employed by ESH is consistent with those established in the ESH CQIP.

Physician assignments are as follows:

Building 2 (Acute admissions services)
Seven psychiatrists are assigned for coverage in Building 2 and one primary care physician.

Building 24 (Forensic services)
Three psychiatrists

Building(s) 25 and 26 (Continuing Rehabilitation Services)
Five psychiatrists and one medical physician

Building(s) 32, 34 and 36 (Geriatric Psychiatric Services)
Four psychiatrists and three medical doctors

Building 4 (Medical Services)
Patients receiving services in Building 4 have a medical problem as the primary focus of care. There are not any psychiatrists assigned to this service. The mental health issues of patients within this building are treated by ESH psychiatrists on a consultant basis. Two primary care physicians and a certified nurse practitioner provide medical coverage.

OIG Finding 4.1: Eastern State Hospital maintains appropriate psychiatrist and primary care physician staffing.

OIG Recommendation: None. Continue this level of medical staffing.

DMHMRSAS Response: Concur. Appropriate staffing of psychiatrist and primary care physician positions will continue to be a high priority at ESH.

2. 24-Hour Medical Coverage

Background: Interviews with administrative staff and a review of policy demonstrated that there was medical and psychiatric coverage provided 24 hours a day. After normal working hours and during the weekends, if the primary physician on grounds is a medical physician, a back up psychiatrist is on call and must be available to come into the facility immediately in the event of urgent mental health related problem. If a psychiatrist is on call, a there is a primary care physician for medical backup.

OIG Finding 4.2: ESH maintains a mechanism for providing round-the-clock on-site medical coverage.

OIG Recommendation: None. Continue this level of access to care.

DMHMRSAS Response: Medical coverage will continue to be available on a 24-hour per day basis at ESH.

3. Falls Prevention Program

Background: The facility has established protocols for a falls prevention program. The primary goals for this program are to decrease the number of falls within the facility and to minimize the severity of injury if a fall occurs. During the initial and annual nursing care assessments, each patient is assessed for the risk of falls. An interdisciplinary

approach to falls risk assessments are used for patients assigned to the Hancock Geriatric Center. Falls risks are assessed through information in the Minimum Data Set (MDS) The MDS assessment is completed every three months.

Patients determined to be at high risk for falls have a falls prevention care plan developed. This includes a number of interventions in the general environmental conditions, such as keeping the patient's room clutter free or through the introduction of specialized equipment such as a walker. The facility has also established a mechanism for reviewing the circumstances associated with falls for the purpose of developing performance improvement initiatives. 15 of the 19 records reviewed by members of the OIG had evidence of completed falls assessments as outlined by policy.

OIG Finding 4.3: A falls prevention program has been implemented and currently is a mature and established part of the assessment process.

OIG Recommendation: None. Maintain this level of monitoring for falls.

DMHMRSAS Response: ESH will continue to monitor, track, and trend data pertaining to the existing falls prevention program.

4. **Dysphasia Program**

Background: The development of a Dysphasia program was agreed to within the ESH Continuous Quality Improvement Plan. This program is managed by a Speech Therapist and is designed to reduce the risk of fatal aspiration and other potential serious problems that can be associated with impaired and painful swallowing. Death from aspiration and associated recurrent pneumonia can be complications of untreated swallowing difficulties, particularly in the geriatric population. Chart review indicated that this program is apparent in the management of a number of individuals in the medical units in building 4 where the majority of patents are at some choking risk. Additionally there were no temporary Naso-gastric tubes in place. For a variety of medical reasons, it is safer long term to use surgically placed gastric tubes. Several patients are fed through gastric tubes in building 4.

OIG Finding 4.4: There was evidence of an established dysphasia program at ESH.

OIG Recommendation: None. Continue the administration of this essential program.

DMHMRSAS Response: ESH will continue with their well-established dysphasia program under the current program guidelines.

5. Use of Barium Swallows

Background: One component of the CQIP specified that modified Barium Swallows would be performed on individuals identified with dysphasia. The Barium Swallow or Upper GI series is an X-ray completed of the upper digestive tract in which barium is

used to enhance the X-ray. In review of 19 records, there was no evidence that Barium swallows were being conducted. This may have been a function of the particular charts that were reviewed.

OIG Finding 4.5: There was not any evidence of modified barium swallows being completed in the charts reviewed.

OIG Recommendation: It is requested that ESH provide information regarding the current policy or practice regarding the use of modified barium swallow in the evaluation of dysphasia.

DMHMRSAS Response: Eastern State Hospital's current document identifying the criteria for use of Modified Barium Swallows (MBS) needs updating and revision, as it does not reflect current practice. All patients who have difficulty swallowing are referred to the speech/language pathologist who may or may not recommend an MBS. The decision to order the MBS is made by the medical staff or treating physician. The protocol will be reviewed and updated by the identified clinical disciplines for approval by the Clinical Cabinet. Estimated Completion date is July 1, 2003.

B. Medication Practices:

1. Medication Treatment Plan

Background: Eastern State agreed to create and maintain a medication treatment plan in the record of each patient treated with psychiatric medication. Interviews with administrative staff revealed that the facility developed a medication form that captures a number of elements important to effective medication management. The plan prominently notes potential side effects. The completion of patient education and documentation of informed consent is a part of this form.

Additional to this, there was concern that at one time patients at ESH did not have adequate access to contemporary psychiatric medications which are generally much better tolerated than older medications, but tend to be very expensive. The Pharmacy and therapeutic committee closely follows trends in use of contemporary medications. In 1999, 60.8% of patients requiring an antipsychotic medication were on the new medication. By 2002 this had increased to 73.5%. (During this same time frame, the cost of the use of these new medications doubled, from an annual cost of .64 million per year for new medications, to a cost of 1.3 million dollars.) Chart reviews indicate widespread use of these new medications although there is some preservation of use of the older medications for the acute management of unstable individuals. It is to the credit of facility administration that there is no policy regarding restriction of access to these new medications. Information is provided to medical staff regarding the cost of these medications.

In a number of charts reviewed there was not clear documentation in the progress notes regarding the purpose of medication change and goal associated with changes. Overall, medication use was appropriately conservative; there is very limited use of PRN medication. The use of two or more antipsychotics for the same patient is uncommon and is tracked through the central pharmacy.

OIG Finding 4.6: In each chart reviewed, there was a medication treatment plan that had been developed for the corresponding patient.

OIG Recommendation: None. Maintain this program, this has been a helpful tool in facilitating a more objective evaluation of the efficacy and risk Vs benefit of each mediation utilized for each patient.

DMHMRSAS Response: ESH will continue to develop medication treatment plans for each patient.

OIG finding: 4.7: Within several charts it was difficult to establish the rationale for change in medication.

Recommendation: Consider a more formal review of this through the Clinical Pertinence Review mechanism.

DMHMRSAS Response: The ESH Medical Records Committee, which handles Clinical Pertinence, will review their current practice and will make recommendations to improve documentation of the rationale for medication change rationale in patient charts.

2. Reporting Adverse Drug Reactions (ADR)

Background: Adverse Drug Reactions (ADR) reporting involves the reporting and tracking of adverse reactions patient have in response to treatment. ESH has created and follows on a monthly basis all reported ADRs. Additionally there is a very thorough annual ADR that is created and reported on to medical staff. The majority of averse reactions are reported by physician staff into this system.

OIG Finding 4.8: Reporting of Adverse drug reaction was systematized and has remained as an integral component of facility administration.

OIG Recommendation: None. Continue this established program that results in increased awareness of the frequency of side effects for all medical staff.

DMHMRSAS Response: Concur. The ESH Pharmacy staff will continue to provide excellent resources to staff on the issue of adverse drug reaction prevention.

C. Psychiatric care:

1. Physician In-services

Background: Interviews with administrative staff and a review of the general medical staff and P& T committee minutes revealed several mechanisms established by the facility for providing continuing education information regarding pharmacology for physicians. The pharmacist has developed a newsletter, which is distributed on a monthly basis to all physicians. In addition, copies are maintained in the back of the formulary book for easy reference.

Training opportunities are provided through the Distant Learning Network and PsychLINK programs. Examples of CME program topics available are: New Vistas in the Treatment of Bipolar Disorder and Antipsychotic Therapy: Understanding Mechanisms of Action to Optimize Patient Response .

OIG Finding 4.9: ESH has several mechanisms established for providing continuing education and training for the physicians including the pharmacy newsletter which serves as a good source of information.

OIG Recommendation: None. There are several opportunities for physicians to maintain a current good working knowledge of standards in contemporary medication and treatment modalities.

DMHMRSAS Response: Concur. ESH will continue to provide vital, up-to-date training on a wide variety of subjects to its physician and professional staff.

2. Clinical Pertinence Review

Background: The current clinical pertinence review process was reviewed. This process was designed in order to monitor the accuracy of diagnosis. Elements are developed and tracked for frequency of successful implementation. Interviews with administrative staff and a review of the medical records committee minutes revealed that there is a well-established on-going quarterly clinical pertinence review process. Among the elements identified in the quarterly reports for psychiatric physicians reviewed were: the completion of history and physicals within 24 hours of admission, the filing of a dictated comprehensive admission summary in the record within 60 hours and the development of a medication treatment plan with a review of side effects for each patient. Elements are changed as the outcome of the monitoring process demonstrates that the goals are consistently100% accomplished. Each major professional discipline at ESH has performance elements that are monitored in this system. The Clinical pertinence review process for psychology staff was also reviewed.

OIG Finding 4.10: ESH has maintained a clinical pertinence review process regarding key performance indicators as established through policy and procedures.

OIG Recommendation: None. This is a well-established process at ESH.

DMHMRSAS Response: Concur.

3. The completion of CT scans for persons diagnosed with dementia.

Background: Interviews with administrative and medical staff revealed that it is a recognized practice at the facility to order CT scans for persons diagnosed with dementia. Of the five records reviewed of individuals diagnosed with dementia there was evidence of the test completed in all five.

OIG Finding 4.11: It is a recognized practice of the facility to obtain CT scans for persons diagnosed with dementia.

OIG Recommendation: None

DMHMRSAS Response: Concur. ESH will continue the practice of obtaining CT scan for dementia patients.

4. General Observations:

There were a number of elements within the ESH Continuous Quality Improvement plan that were not reviewed in detail with this inspection. In general it is evident that the structure of the multidisciplinary treatment planning process is intact and operational in each of the treatment areas at ESH. The clinical pertinence review process that focuses highly on monitoring this process supports this.

The treatment mall, which was developed to address the concerns that patients at ESH were not receiving active treatment, is well established and continues to provide a variety of programming designed to promote recovery and successful adaptation to facility and community life. Additional to the central treatment mall for longer-term mentally ill persons, there are numerous treatment opportunities for patients within the admission unit as well as on the Geriatric unit.

Review of the discharge plans in several charts found that the involvement of corresponding Community Service Board discharge planning staff in the discharge process was variable. For some individuals there was good documented involvement of the CSB, for others there was virtually no involvement. Given the current initiative to reorganize services in this region by way of a transfer of facility resources in order to enhance community services, communication and coordination around discharge as well as admissions will need to be reviewed.

PETERSBURG, VIRGINIA
JOHN HOLLAND, MD / FACILITY DIRECTOR

A Secondary Inspection was conducted at Southside Virginia Training Center on May 7, 2003. The purpose of a secondary inspection is to conduct an unannounced inspection in response to a specific complaint or issue that may a life, health, or safety concern, or other potential breech in quality of care. Information contained in the report is not available because it contents were intended for peer review deliberation.

OIG Report #82-03
SOUTHEASTERN VIRGINIA TRAINING CENTER
CHESAPEAKE, VIRGINIA
ROBERT SHREWSBERRY, PHD / FACILITY DIRECTOR

A Snapshot Inspection was conducted at Southeastern Virginia Training Center in Chesapeake, Virginia on Sunday and Monday, May 18 and 19, 2003. The purpose of the snapshot inspection was to conduct an unannounced review of this facility with a primary focus on three essential areas that are directly related to a facilities capacity to provide quality care. The areas are: the general conditions of the facility, staffing patterns and concerns and the activity of residents.

This inspection noted that there was more staff on site during the weekend hours toured than had been experienced in a previous inspection. Environmental conditions were clean, odor free and overall, the facility was well maintained. Staff members were observed monitoring all residents and participating in individualized and group active treatment activities during the day and evening shifts in which tours were conducted.

PART I: STAFFING ISSUES

1. Number of staff scheduled for this shift for this unit. DSA= Direct Service Associate	**May 18 – Evening Shift** Bldg 28 – 19 residents 4 DSA's Bldg 1A – 10 Residents 3 DSA's Bldg 1B- 7 Residents 2 DSA's Bldg 1C – 10 Residents 2 DSA's Bldg 1D – 7 Residents 2 DSA's **May 19 – Day Shift** Bldg 2B – 10 Residents 3 DSA's Bldg 3D – 10 Residents 3 DSA's Bldg 4A - 8 Residents 2 DSA's Bldg 5C - 8 Residents 3 DSA's
2. Number of staff present on the unit?	Observations of unit staffing revealed that staffing was present as indicated above.
3. Number of staff doing overtime during this shift or scheduled to be held over?	Interviews indicated that no staff were working overtime during this inspection.
4. Number of staff not present due absence because of workman's compensation injury?	Interviews with facility staff during the inspection indicated that there were not any staff out on workers compensation leave.
5. Number of staff members responsible for one-to-one coverage during this shift?	Interviews with facility staff indicated that during the inspection of the two shifts on the units listed above indicated that 3 staff were responsible for a 1:1 coverage, either in-sight or arms length distance.

6. Are there other staff members present on the unit? If so, please list by positions?

During the inspection on the day shift activities therapists and Team Leaders were noted in the cottages and during the night shift, an LPN was noted to be making rounds.

7. Additional comments regarding staff: OIG staff had the opportunity to speak with a parent that was visiting and he was very pleased with the staff that cared for his son. He had nothing but accolades when discussing the atmosphere in which his son lived.

Finding 1.1: Staffing levels as established and maintained by the facility currently meet the individual needs of residents. Given the complexity of these residents, these are very minimal staffing patterns and leave the facility overall with little margin which is tightly bound to the local economy.

OIG Recommendation: Provide on-going assessment of the needs of residents and maintain staffing levels appropriately. At some point the Commonwealth will need to review the stable competitiveness of starting salaries for direct care staff in training centers.

DMHMRSAS Response: SEVTC will continue to monitor resident needs and adjust staffing accordingly within available resources. The Department's Human Resource Office through the Workforce Development Initiative has recently undertaken a salary survey of facilities, CSB's and private providers to determine comparability. Early results of this survey demonstrate that the Department is competitive in the market and provides greater benefit packages than the private provider. The Department would be please to share this report with the OIG after completion.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

During the review, the census during the time of the inspection was found to be:

Capacity:	**Census:**
Bldg 28 – 20 Residents	19 residents
Bldg 1A – 10 Residents	10 Residents
Bldg 1B- 8 Residents	7 residents
Bldg 1C – 10 Residents	10 Residents
Bldg 1D – 8 Residents	7 Residents
Bldg 2B – 10 Residents	10 Residents
Bldg 3D – 10 Residents	10 Residents
Bldg 4A - 8 Residents	8 Residents
Bldg 5C - 8 Residents	8 Residents

3. Number of patients/residents on special hospitalization status

Interviews with staff indicated that during the inspection period, one resident was on special hospitalization status, but did not require staff coverage while hospitalized.

4. Number of patients/residents on special precautions?
Interviews with staff on the units inspected indicated that 41 residents (or about half of the residents) were noted to have a special precaution addressing issues for falls, aggressive behavior, elopement, self-injurious behavior, pica, or depression.

5. Number of patients/residents on 1 to 1?
Interviews with facility staff indicated that during the inspection of the two shifts on the units listed above indicated that 3 staff were responsible for a 1:1 coverage, either in-sight or arms length distance.

6. Identify the activities of the patients/residents?
During the two shifts in which the OIG staff toured residential areas, meals were being served and OIG staff sent time witnessing this occurrence. Overall, this was a very smooth process, in which a portion of the staff prepared the meals and set up place settings as guided by the nutritional management plan, while the other portion of staff continued to interact with residents individually. During the observation of the dinner meal in Bldg 28, it was noted that a large dining room was being set up and meals were being prepared and set out individually. From the first meal set to the last meal and everyone beginning to eat, approximately 30 minutes had passed. This time delay could result in temperature changes making eating a less enjoyable experience for the residents. This delay could be a function of limited staffing patterns.

7. What scheduled activities are available for patients/residents during this shift?
When the OIG staff toured residential areas on the evening shift, dinner preparation and leisure time was occurring. Some staff was interacting individually with clients or in groups while other staff prepared the dinner meal. After dinner, staff and residents engaged in either one to one programming activities or participated in games, crafts, hygiene, music, and leisure activities. During the day visit, OIG staff observed that many residents were attending group, such as the Social Community Group; or activities around campus including recycling or changing trash can liners. Many of the residents remaining the cottage and do not leave for groups. The activities that are conducted in the cottage include: speech; meal prep; grooming and hygiene; table setting; exercise group; and outdoor leisure activities. The OIG member was also informed that a number of residents were involved in off-site training such as school.

8. Are smoke breaks posted?
Tours indicated that out of the 9 units 2 of the units had 1 resident each that smoked. In one of the cottages a smoke break was posted and in the other cottage the staff and resident were aware of the schedule.

9. Do patients/residents have opportunities for off-ground activities?
Facility staff indicated that off ground activities conducted and include events like, trips to parks for picnics and BBQ's; movie outings; sporting events; bowling; going to the mall; and walking on the beach.

10. As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans.

11. Other comments regarding patient activities: None

OIG Finding 2.1 There were a variety of therapeutic activities available which were appropriate and individually based. A review of the schedules revealed that these activities were occurring as scheduled.

OIG Recommendation: Continue to offer a wide variety of appropriate therapeutic activities.

DMHMRSAS Response: This will receive on-going attention from staff at all organizational levels.

OIG Finding 2.2: Observations indicated a considerable lapse in time between meals being served and residents brought to the table for consumption in building 28.

OIG Recommendation: Explore options for decreasing this time lapse in this building.

DMHMRSAS Response: The ID team will monitor the time between serving and consumption to determine whether the observation indicates a systemic problem. If so, the team will determine what steps must be taken to sharply reduce this time. If not a systemic problem, staff members will be given more specific guidelines regarding time between serving and consumption and supervisors will monitor.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
1. The common areas are clean and well maintained.	Tours indicated that the residential areas visited were clean and well maintained.
2. Furniture is adequate to meet the needs and number of patients/residents.	Tours of selected units indicated that furniture was adequate to meet the needs of residents. Many pieces had been adapted for specific individuals and their positioning needs.

3. Furniture is maintained and free from tears.	Tours of residential and common areas indicated that furniture was free from tears and well maintained.
4. Curtains are provided when privacy is an issue.	Tours of residential units demonstrated that window coverings are provided for privacy from the outside. There are some residents with behaviors that will consistently tear down curtains, the facility works to be innovative in other forms of window shading.
5. Clocks are available and time is accurate.	On all areas toured clocks were available in public areas and had the correct time.
6. Notification on contacting the human rights advocate are posted.	Tours of each unit indicated that a poster providing information on how to contact the Human Rights Advocate is posted in a public area of each unit.
7. There is evidence that the facility is working towards creating a more home-like setting.	All residential units toured indicated that the facility was working towards a more homelike atmosphere as appropriate for the population. Each residential unit had different homelike aspects. The areas were decorated with stenciling, faux plants, specialized furniture, pictures, resident made crafts and stuffed animals. All areas had a TV and music available for clients.
8. Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable, even though it was unseasonably cool.
9. Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours of residential areas indicated that there were areas in each building for visits by family. In one cottage OIG staff were able to speak with a parent that was visiting.
10. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature anytime.
11. Hallways and doors are not blocked or cluttered.	This has been a difficult challenge for this facility. The buildings were designed for a population that did not require the amount of materials as the current residents. The facility has improved over time and continues to make an effort to keep hallways clear of needed items.

	The facility has a storage shed for each cluster of buildings and staff indicated that did help.
12. Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
13. Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff indicated that fire drills are conducted once per shift per month and residents were aware of where to go for safe egress.
14. Fire drills are conducted routinely and across shifts.	Interviews with staff indicated that fire drills are conducted once per shift per month and residents were aware of where to go for safe egress.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well-maintained.	All residential units toured were clean and well maintained.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of all residential areas indicated that each resident has a mattress, sheet, blankets and pillow and if more is needed can be obtained upon request.
3. Curtains or other coverings are provided for privacy.	Tours of the residential units confirmed that curtains and other coverings are provided for clients' privacy.
4. Bedrooms are free of hazards such as dangling blind cords, etc.	The residential areas toured were free from hazards. Small hooks designed for securing blind cords were in place.
5. Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients are given the opportunity to personalize their rooms.
Seclusion Rooms	**Comments and Observations**

1. Seclusion and/or time out rooms are clean.	Tours and observations indicated that time out rooms are clean.
2. Seclusion and/or time out rooms allow for constant observations.	Tours of unit time out rooms do allow for constant observation.
3. Bathrooms are located close to the seclusion or time-out areas.	Tours of units indicated that time out rooms are located near bathrooms.
Bathrooms	**Comments and Observations**
1. Bathrooms were clean and well maintained	Tours of unit bathrooms indicated over all bathrooms were clean. There were four toilets left unflushed and 1 toothbrush on the floor and 1 towel on the floor. In addition, one bathroom had toilet paper with brown smeared on it, but there was not an odor.
2. Bathrooms were noted to be odor free.	Tours of unit bathrooms across all shifts indicated that all were odor free.
3. Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that overall were free of hazardous conditions. In one bathroom, a used latex glove was left on the bathroom floor.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well-lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
2. Grounds are maintained.	A combination of walking and driving tours of the grounds confirmed that they were well maintained.
3. There are designated smoking areas with times posted.	Tours on selected units did not reveal any residents that smoked.
4. Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients with the appropriate privileges regularly go outside on and off grounds.

Other comments regarding the environment: Since the last inspection, sharps boxes have been placed in appropriate locations to correctly dispose of hazardous sharp materials. Staff was aware of the location of these boxes and proper usage.

Additionally, several renovation projects have been completed, including hall monitoring cameras and a renovated kitchen in Building 28. The renovations to this building have offered the staff the ability to prepare individual meals while being aware of the residents' movements.

OIG Finding 3.1: Tours of 9 units revealed the facility overall was generally clean and well maintained.

Recommendation: Many improvements were noted regarding the cleanliness of the environment since the previous OIG inspection. Maintain this progress in assuring an environment that is clean and free of hazards.

DMHMRSAS Response: Clean and homelike cottage environments will remain a facility priority.

OIG Report # 83-03
CENTRAL VIRGINIA TRAINING CENTER
LYNCHBURG, VIRGINIA
JUDY DUDLEY / FACILITY DIRECTOR

A Snapshot Inspection was conducted at Central Virginia Training Center in Lynchburg, Virginia on June 3-5, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

CVTC is one of five training centers dedicated to providing residential and active treatment services to persons with mental retardation. This facility primarily serves individuals from the central region of the state but accepts admissions from across the Commonwealth. On the initial day of this inspection, the census of the facility was 608 residents. This represents a reduction of approximately 20 residents since the 2002 OIG inspection. CVTC continues to downsize through admission diversions, discharges, and transfers to other facilities. Once ranked the largest facility of its kind in the nation with a peak census of 3600, it currently is reported as the ninth largest.

CVTC has been the focus of a conjoint review by the OIG and the Virginia Office of Protection and Advocacy (VOPA) due to a high resident injury rate. Many improvements have been made since that time. A detailed comprehensive review of hazards within the physical environment was conducted and is part of the ongoing management of this facility. The role of professional rehabilitation staff was thoroughly reviewed such that now rehabilitation staff are routinely involved in the analysis of injuries. They provide focus on the prevention of future similar incidents. Additionally rehabilitative staff are now deployed and accessible throughout the facility as opposed to the previous more isolated consultant role.

During this inspection, the facility was noted to be well maintained, clean and comfortable. CVTC maintains the minimal staff to client ratio allowing for the provision of training while addressing the care and safety needs of the residents it serves. Residents at CVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning.

One area of continued concern at this facility centers on the limited availability of psychiatric care including regular follow-up and consistent involvement of psychiatric personnel in on-going treatment.

PART I: STAFFING ISSUES

1. Number of staff scheduled for this shift for this unit. DSA= Direct Services Associate	**June 4 – Day Shift** Unit 17A – 15 residents 6 DSA's (1 trainee), .5 LPN Unit 17B – 13 residents 6 DSA's (1 trainee), .5 LPN Unit 17D – 14 residents 6 DSA's (1 trainee) Unit 16A – 13 Residents 4 DSA's Unit 16B - 13 Residents 5 DSA's Unit 18A – 14 Residents 4 DSA's Unit 18C – 9 Residents 5 DSA's (1 trainee) Unit 31D – 20 Residents 2 LPN's, 5 CNA Unit 31B – 20 Residents 1RN, 1 LPN, 4 DSA's **June 4 – Evening Shift** Unit 2B - 13 Residents 4 DSA's Unit 2C – 11 Residents 3 DSA's
2. Number of staff present on the unit?	OIG staff noted that the actual staffing patterns varied somewhat from those identified above. Interviews with administrative staff revealed that those noted to be absent from the units were with individual clients off the residential unit.

3. Number of staff doing overtime during this shift or scheduled to be held over?	Interviews indicated that 4 staff were working overtime during the evening shift. Even though it is the goal of the facility to limit the use of mandatory overtime through several deployment strategies such as scheduling and the use of voluntary overtime, the actual amount of overtime remains relatively high due to limited staffing.
4. Number of staff not present due absence because of workman's compensation injury?	OIG interviews conducted with staff during the inspection discovered that no staff members were out on workers compensation leave.
5. Number of staff members responsible for one-to-one coverage during this shift?	Interviews with facility staff indicated that during the inspection of the two shifts on the units listed above 4 staff members were responsible for a 1:1 coverage. This was either "within-sight" or "at arms length" due to self-injurious or aggressive behavior precautions. Other residents require special oversight for particular segments of their training programs but those individuals were not identified in this section.

6. Are there other staff members present on the unit? If so, please list by positions?
At some point during the inspection, OIG staff noted that Program Administrators, QMRP's, RNs, Med Aide and M.D. were all present on the units for various periods of time. On one specific unit a team including nurse, psychologist, psychiatrist, and social worker were present to work with a patient.

7. Additional comments regarding staff:
CVTC has experienced difficulty in recruiting and retaining direct care staff, particularly in the direct services associate positions. A review of staffing patterns over a month time-period and during the course of the inspection indicated that the facility operates with the minimum ratios for staff to residents. Many efforts have been implemented to engage an adequate workforce to address the training, care and safety needs of the residents. One such effort is to continue to downsize the census through admission diversions, discharges, and transfers to other facilities. Once ranked the largest facility of its kind in the nation, it currently is reported as the ninth largest.

One area of continued concern for this facility is the limited availability of psychiatric coverage. Interviews with administrative staff, a review of ten records for individuals on psychotropic medications and a review of six behavioral management plans demonstrated this facility's ongoing need for additional psychiatrist staff in order to address the needs of the residents. CVTC has requested assistance from the Central Office and the OAG in

reviewing the possibility of a psychiatrist from another state facility traveling to CVTC in order to support the work of the full-time staff psychiatrist. Approximately 230 residents are currently on psychotropic medications at the facility. Each person placed on these medications has a behavioral plan developed. Given the behavioral complexities of these individuals, as well as comparing this with other training centers in Virginia, the current number of psychiatrist hours is insufficient. This issue will be important for this facility to address in order to effectively manage the needs of these residents.

Finding 1.1: Direct observation, interviews and a review of staffing documentation revealed that the facility provided for adequate staffing patterns. This is consistent with facility policy and provides for treatment and safety concerns of the residents.

OIG Recommendation: Continue current levels of staffing.

DMHMRSAS Response: CVTC continues its on-going efforts to maintain current levels of staffing.

Finding 1.2: CVTC continues to function with limited psychiatric coverage.

OIG Recommendation: It is important for this facility to address this issue in order to effectively manage the treatment needs of these residents. As the facility is currently in the process of working with the Central Office and the Office of the Attorney General in reviewing the possibility of a psychiatrist from another facility traveling to CVTC in order to support the work of the full-time staff psychiatrist, no additional recommendations are made at this time. The OIG will be monitoring this issue closely.

DMHMRSAS Response*:* CVTC is pleased to report some progress in obtaining additional psychiatric services. A psychiatrist has been obtained via a contract with a Locum Tenens agency. The psychiatrist will begin providing services to the facility by August 1, 2003. Initially the psychiatrist will work one to two days a month. In addition, the DMHMRSAS Workforce Development Manager will be providing CVTC with technical assistance for recruitment and retention efforts.

CVTC continues the recruitment for additional psychiatric coverage. The psychiatrist position is currently listed on the Department's "Hot Job" Website. Additionally, CVTC's Director of Procurement has contacted two agencies having the "locum tenens" state contract to determine if psychiatric services can be obtained via their agencies. Two prospective candidates from *Staff Care*, one of the agencies, are considering the position. *Staff Care's* recruitment department is also seeking other prospects as well. Another locum tenes contractor has been involved in the staff search as well.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

During the review, the census of all three shifts was found to be:

Capacity:	**Census:**
Unit 17A – 15 residents	15 residents
Unit 17B – 14 residents	13 residents
Unit 17D – 14 residents	14 residents
Unit 16A – 13 Residents	13 residents
Unit 16B - 13 Residents	13 residents
Unit 18A – 14 Residents	14 residents
Unit 18C – 9 Residents	9 residents
Unit 31B – 20 Residents	20 residents
Unit 31D – 20 Residents	20 residents
Unit 2B - 13 Residents	13 residents
Unit 2C – 11 Residents	11 residents

3. Number of patients/residents on special hospitalization status
Interviews with staff indicated that during the inspection period, one resident was on special hospitalization status. CVTC has a medical facility on campus where persons can receive routine medical services and observation. Special hospitalization status as in the case referred to, the person was receiving medical care in the local off grounds hospital.

4. Number of patients/residents on special precautions?
Interviews with direct care staff, on the units toured, indicated that residents were noted to be on special precautions addressing issues such as falls, aggressive behavior, self-injurious behavior, and/or pica.

5. Number of patients/residents on 1 to 1?
Interviews with facility staff indicated that during the inspection of the two shifts on the units listed above indicated that 4 staff were responsible for a 1:1 coverage, either "within-sight" or "at arms length" distance.

6. Identify the activities of the patients/residents? During visits to several of the units residents were observed to be actively engaged in training and rehabilitative activities. This particular tour was focused on observing the physical management and rehabilitation of individuals.

7. Are smoke breaks posted?
Smoke breaks are allowed for those individuals who smoke, however, interviews with staff in the units toured indicated that there were not any persons who smoked residing on these units.

8. Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff indicated that residents go on bus rides, train rides, to local parks, out shopping, to the Safari Park, restaurants, to play putt-putt, to dances in the community, the zoo, the circus, and movies and a variety of other activities.

9. As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans. Snack breaks often occur around 10am, 2pm and 8pm.

10. Other comments regarding patient activities:

A significant administrative change that has occurred over the last year is the reconfiguring of rehabilitative services at CVTC. Previous to the CVTC-VOPA report issued in December 2000, access to rehabilitative services was primarily based on a consultation service model. Access to these professionals was limited to those who were referred by medical staff. Treatment was generally episodic as opposed to ongoing. Given the serious physical mobility problems experienced by the great majority of individuals within CVTC, individuals were at risk of losing function and experiencing unnecessary morbidity due to lack of attention to the physical management needs of very impaired individuals. (Examples include rubbing abrasions and repetitive motion injury due to ill fitted wheel chairs, fracture risk associated with improper transferring or lifting, repeated tripping, blood clots from inactivity, aspiration (or choking down food) and bed sores.) Too few individuals had access to vital physical management and rehabilitative services. At this time, the rehabilitation staff, which includes occupational and physical therapy staff are permanently stationed throughout the facility. This alone has increased the general staff exposure to these professionals and has resulted in many positive benefits for residents. In addition to a growth in the number of professionally developed and updated physical management plan, rehabilitative staff have been much more in contact with direct care staff. There are daily ongoing opportunities for exchange between this level of professional and direct care staff. This has raised the overall level of competence and sophistication of all staff in residential areas. Rehabilitative staff state that this has worked well for them and has added a new level of professional satisfaction in that they are much more consistently working as part of a team wherein they exchange information that ultimately helps them help the residents to a greater degree than in the situation of being only a consultant. It was very inspiring to tour the facility with rehabilitative staff and see the genuine compassion and skill they bring to these disabled citizens. It is very important to have a mix of professional with paraprofessional staff in providing quality care to these individuals. Being able to hire qualified professionals competitively is important. Concerns were described regarding current advertising and hiring practices for rehabilitative professionals.

OIG Finding 2.1: Reviews of resident schedules and direct observation reveal that individuals residing within CVTC have access to numerous activities that are individually designed to meet that individual's perceived need.

OIG Recommendation: Continue to offer solid active treatment programming for these residents.

DMHRSAS Response: DMHMRSAS concurs. We appreciate recognition by the Inspector General of the strides that the facility has made in providing solid, active treatment programming. The CVTC Assistant Director for Program Services as well as the Rehabilitation staff will continue to work with direct care staff on issues related to active treatment.

OIG Finding 2.2: Concern was raised by multiple staff regarding hiring issues related to rehabilitative staff. This is an issue at other training centers as well, most recently SVTC has reconfigured the way it advertises for rehabilitative professionals.

OIG Recommendation: DMHMRSAS should consider reviewing contemporary best practices for hiring rehabilitative professionals in training centers. A meeting or forum through which ideas regarding hiring these professionals is exchanged is recommended.

DMHMRSAS Response: The DMHMRSAS Workforce Development Manager will be providing CVTC with technical assistance for recruitment and retention of rehabilitation staff.

The facility's rehabilitation job vacancies are listed on the Department's "Hot Job" Website. This allows for individuals seeking a quick glance for vacancies to query on specific jobs such a registered physical therapist/occupational therapists. Rehab positions are *on continuous recruit*, and positions will be advertised nationally in professional journals such as the Occupational Therapist Journal and the Physical Therapy Advance.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
1. The common areas are clean and well maintained.	Tours indicated that the residential areas visited were clean and well maintained. Virtually every residential area at CVTC was observed in the course of this inspection.
2. Furniture is adequate to meet the needs and number of patients/residents.	Tours of units indicated that furniture was adequate to meet the needs of residents. Many pieces had been adapted for specific individuals and their positioning needs.

3. Furniture is maintained and free from tears.	Tours of residential and common areas indicated that furniture was free from tears and was well maintained.
4. Curtains are provided when privacy is an issue.	Tours of most living units demonstrated that blinds and curtains are provided for privacy from the outside.
5. Clocks are available and time is accurate.	On all areas toured clocks were available in public areas and had the correct time.
6. Notification on contacting the human rights advocate are posted.	A tour of each unit indicated that posters providing information on how to contact the Human Rights Advocate was posted in a public area on each unit.
7. There is evidence that the facility is working towards creating a more home-like setting.	All residential units toured indicated that the facility was working towards a more homelike atmosphere as appropriate for the population. Each residential unit had different homelike aspects. Observations noted areas decorated with stenciling, faux plants, specialized furniture, pictures, resident made crafts and stuffed animals. All areas had a TV and music available for clients.
8. Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable.
9. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature, anytime they wanted.
10. Hallways and doors are not blocked or cluttered.	Tours demonstrated that the facility has made an effort to remove physical obstacles. Hallways and doorways were noted to be free of clutter and obstacles.
11. Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
12. Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff and residents indicated that fire drills are conducted once per shift per month and residents were aware of where to go for safe egress.

13. Fire drills are conducted routinely and across shifts.	Interviews with staff and residents indicated that fire drills are conducted once per shift per month and residents were aware of where to go for safe egress.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well-maintained.	All residential units toured were clean and well maintained.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of all residential areas indicated that each resident has a mattress, sheet, blankets and pillow and if more is needed can obtain them upon request.
3. Curtains or other coverings are provided for privacy.	Tours of the residential units confirmed that curtains and other coverings are provided for clients' privacy.
4. Bedrooms are free of hazards such as dangling blind cords, etc.	The residential areas toured were free from hazards such as dangling cords from blinds or equipment.
5. Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients are given the opportunity to personalize their rooms.
Seclusion Rooms	**Comments and Observations**
1. Seclusion and/or time out rooms are clean.	Not applicable.
2. Seclusion and/or time out rooms allow for constant observations.	Not applicable.
3. Bathrooms are located close to the seclusion or time-out areas.	Not applicable.

Bathrooms	Comments and Observations
1. Bathrooms were clean and well maintained	Tours of unit bathrooms indicated overall that bathrooms were clean. Three toilets were not flushed.
2. Bathrooms were noted to be odor free.	Tours of unit bathrooms across all shifts indicated that all were odor free.
3. Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions. The facility has worked to identify and correct obstacles in bathrooms.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well-lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
2. Buildings are identified and visitor procedures for entry posted.	Upon entering the center all visitors are greeted by staff and asked to identify themselves with a badge or other form of identification.
3. Grounds are maintained.	A driving tour of the grounds confirmed that they were well maintained.
4. There are designated smoking areas with times posted.	Tours on selected units did not reveal any residents that smoked.
5. Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients with the appropriate privileges regularly go outside on and off grounds.

Other comments regarding the environment:

OIG Finding 3.1: Overall, the environment was well maintained, clean and comfortable.

Recommendation: CVTC administration and staff have focused an effort on identifying, correcting and maintaining potential hazards within this setting. No additional recommendations are warranted.

DMHMRSAS Response: DMHMRSAS concurs. DMHMRSAS appreciates the efforts made by CVTC staff to significantly improve the internal environment. Be assured that CVTC's leadership will continue their monitoring efforts to maintain the improvements and to seek further possible improvements.

OIG Report #84-03
SOUTHWESTERN VIRGINIA TRAINING CENTER
HILLSVILLE, VIRGINIA
DALE WOODS, ED.D / FACILITY DIRECTOR

A Snapshot Inspection was conducted at Southwestern Virginia Training Center in Hillsville, Virginia on June 24-25, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

SWVTC is one of five training centers dedicated to providing residential and active treatment services to persons with mental retardation. On the day of the inspection, the census of the facility was approximately 200 residents. The team conducted tours of seven cottages and one large residential building. In addition, active treatment programming was observed.

Overall, the facility was clean comfortable and well maintained. The team noted that the facility has updated the appearance of several cottages, including some specialized painting techniques, which provides for an attractive environment.

SWVTC maintains a minimal staff to client ratio enabling the provision of training, care and supervision of the residents served. Residents at SWVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning.

The team was informed that the facility has advertised for a full-time psychiatrist and a doctorate level psychologist. The addition of these positions will enable the facility to enhance its services.

PART I: STAFFING ISSUES

1. Number of staff scheduled for this shift for this unit. DSA= Direct Service Assistant	**June 24, 2003 / Day Shift** Building 12A - 11 residents 2.5 DSAs Building 12B - 11 residents 2.5 DSAs Building 5C - 8 residents 2 DSAs **June 24, 2003 / Evening Shift** Building 6B - 8 residents 2 DSAs Building 7B - 10 residents 3 DSAs (Please note that one of the DSAs from the day shift continued into the evening shift because of doing 1:1 coverage until 5:30 pm) Building 8C - 10 residents 3 DSAs (Please note that one of the DSAs has a regular shift that covers from 1:30-9:30pm)

2. Number of staff present on the unit?	**June 24, 2003 / Day Shift** All of the staff except those mentioned below were accompanying the residents for programming, which explains why staff were not observed on the units when toured. Staffing at the programming sites will be addressed in Part Two of this report. Building 12A – 0 Building 12B - 1 DSA Building 5C - 0 **June 24, 2003 / Evening Shift** Building 6B - 2 DSAs Building 7B - 1 DSA Building 8C - 0
3. Number of staff doing overtime during this shift or scheduled to be held over?	Interviews with staff revealed that during the inspection four were noted to be doing overtime. Building 12A – 2 Building 12B – 1 Building 7B – 1
4. Number of staff not present due absence because of workman's compensation injury?	Interviews revealed that no staff were absent due to a worker's compensation injury.
5. Number of staff members responsible for one-to-one coverage during this shift?	Staff informed the team that 2 residents in the areas toured were on 1:1 due to behavioral or medical issues.

6. Are there other staff members present on the unit? If so, please list by positions?
It was noted that team leaders were on 2 of the units during the time of the tour. Housekeeping staff were noted on one of the units.

7. Additional comments regarding staff: There has been noted improvement in staffing patterns at this facility over the last three inspections. SWVTC used the funding provided to the facility through a special allocation to hire a number of direct care workers, which has enabled the facility to meet minimal staff to resident ratios without unsafe use of overtime. Interviews and observations demonstrated that the use of this funding to increase staffing patterns has had an extended positive effect on staff morale.

Finding 1.1: Observations revealed that the facility has increased the number of direct care staff. This enables them to meet the minimal staffing patterns consistent with facility policy without the excessive and unsafe use of overtime.

OIG Recommendation: SWVTC has prioritized the hiring of additional direct care staff in order to enhance its ability to provide for the care and supervision of its residents. It will be important for both the facility and the Central Office to maintain these gains.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of SWVTC's and Central Office efforts to maintain staffing gains.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

During the review, the census during the inspection was found to be:

Capacity:	**Census:**
Building 12A - 11 male residents	11 residents
Building 12B – 11 female residents	11 residents
Building 5C - 8 residents	8 residents
Building 6B - 8 residents	8 residents
Building 7B - 10 residents	10 residents
Building 8C - 10 residents	10 residents

3. Number of patients/residents on special hospitalization status
At the time of this inspection, it was noted that one individual was hospitalized due to a recent injury.

4. Number of patients/residents on special precautions?
Interviews with staff indicated that 3 residents were on special precautions due to risk for fall, 4 due to self-injurious behaviors, 6 due to aggressive behaviors and 2 on aggressive and self-injurious behavior.

5. Number of patients/residents on 1 to 1?
Staff informed the team that 2 residents in the areas toured were on 1:1 due to behavioral or medical issues.

6. Identify the activities of the patients/residents?
A member of the team observed active treatment programming in the Recreational Building during the afternoon session, which occurs from 1:30pm – 4:30pm. Residents were participating in music therapy, speech therapy, and recreational therapeutic activities in the gym and nautilus room. It was evident that there were cooperative relationships between the professional and direct care staff to ensure the completion of active treatment programming. Staff were noted to be engaged with the residents in a relaxed manner, treating each individual with respect and dignity.

Music Therapy- Seven residents were engaged in the music therapy session observed by the team. There were two staff members in the room, one of which was a music therapist. The group was involved in an activity designed to enhance color recognition, movement and dexterity. The therapist worked to engage each person in the activity providing support and direction as needed.

Throughout the activity, residents were removed for a brief period of time to complete programming in the nautilus room. It was explained that this was due in part to limited staffing available on this date as one of the cottages was off-site on a field trip and staff normally assigned to the building were accompanying the residents.

Speech therapy- Four residents were engaged in speech therapy during the session observed. There were two staff members present, including a speech therapist. The therapist used Touch and Tell Boards to engage each resident in picture and sound recognition. The therapist's interaction with the resident demonstrated a comfortable rapport and knowledge of each participant. Humor, support and praise were used to encourage involvement. Normally this session served more residents but those identified for participation, included persons on the field trip.

Recreational therapy - The gymnasium was divided into two separate recreational activities. On one side of the gym, six residents were engaged in a movement activity that involved walking around the area in a circle and throwing several balls. There were two staff members present.

On the other side of the gym, a group of eight residents were throwing basketballs. Four staff members were present and actively engaged with each of the residents.

There were three staff members in the Nautilus room each providing 1:1 monitoring and instruction to the residents participating. Interviews with staff demonstrated an understanding of the goal for involvement for each person participating.

7. What scheduled activities are available for patients/residents during this shift?
Interviews and a review of scheduled activities demonstrated that residents were also engaged in vocational programs including paper shredding, can crushing and recycling, sock matching and folding, and woodworking. A number of residents are also engaged in work associated with preparation and clean-up of utensils and trays following the morning and afternoon meals.

Residents in Cottage 5A were off campus on a field trip to a matinee and lunch. Residents were noted to be very excited about this event upon their return and were actively encouraged by staff to discuss their experiences. Staff related that residents participate in a number of off grounds activities, such as shopping, picnics, hikes, miniature golf, attending ball games, going to restaurants and touring a drive-through zoo. Residents also have opportunities to participate in special events within the community such as a hot air balloon show.

8. Are smoke breaks posted?
There are designated smoking areas, primarily for staff. Interviews indicated that in the areas toured there were not any residents that smoked.

9. Do patients/residents have opportunities for off-ground activities?
As noted above in #7, residents at this facility are afforded a number of opportunities to be involved in off ground activities.

10. As appropriate, do patients/residents have opportunities for snacks?
Snacks are available, as appropriate and dictated by dietary needs as determined by their physician. Afternoon snacks were available during designated break times during the activities.

11. Other comments regarding patient activities: None

OIG Finding 2.1: SWVTC offers a variety of active treatment options for its resident based upon their individual needs and abilities. Staff were observed in a variety of situations treating the residents with dignity and respect.

OIG Recommendation: None. Staff were well-versed on the active treatment goals for the residents and provided supervision, support and praise in actively engaging the residents.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
1. The common areas are clean and well maintained.	Tours of nine living areas during the day and evening shifts indicated that the common areas are clean and well maintained.

2. Furniture is adequate to meet the needs and number of patients/residents.	Tours of nine residential units indicated that the furniture in common areas and in bedrooms meets the needs of the patients.
3. Furniture is maintained and free from tears.	All furniture observed during tours of the residential units was free of tears and was well maintained.
4. Curtains are provided when privacy is an issue.	Tours and observations indicated that curtains are provided for privacy. In the instance where a curtain or blind does not meet the needs of a resident, the facility has been creative in order to produce the privacy that a residents has a right to, such as the application of opaque window coverings that are stuck to a window. This covering allows light in and the residents can see out, but no one can see in, so it provides privacy while addressing the behavioral issues of several residents.
5. Clocks are available and time is accurate.	Observations during tours of residential areas indicated that all clocks were accurate.
6. Notification on contacting the human rights advocate are posted.	Observations during tours indicated that each residential area visited by OIG staff had a human rights poster placed in a common area.
7. There is evidence that the facility is working towards creating a more home-like setting.	Tours of nine units indicated that this facility works to create a more home like setting. All units visited had nice paint and borders up in all rooms, plus there were faux plants, rugs, pictures, murals on walls, decorative draperies, a TV and radio in an entertainment center and trinkets to decorate common areas. Specifically, Cottage 5C, which has had problem keeping anything on the walls do to the behavior of several residents has had the décor renovated recently. Staff donated time to repaint the entire cottage, using faux stucco painting techniques to give the common areas and bedrooms a light, open decorated feel, without using anything that could be destroyed. Other observations made while touring units indicated that bedrooms were decorated with murals, different colors of paints, wall paper borders, pictures, matching bed sets, rugs, special pieces of furniture, personal memorabilia, wall shelves, bookshelves, TV's,

	radios and window treatments.
8. Temperatures are seasonally appropriate.	Tours of units indicated that on a very warm summer day the residential areas were cool and comfortable.
9. Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours revealed that each residential area has space for visits with family. Specifically, a parent has recently led a donation campaign in order to establish a special room in the infirmary for parents to be with their children during the resident's time of ill-health, decline and death.
10. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that residents have access to writing materials and telephones.
11. Hallways and doors are not blocked or cluttered.	Tours and observations indicated that hallways and doors in the residential areas were not blocked or cluttered.
12. Egress routes are clearly marked.	Tours and observations indicated that egress routes were clearly marked.
13. Patients/residents are aware of what procedures to follow in the event of a fire.	OIG staff were unable to speak to residents due to the time of day in which the inspection was conducted, residents were in programming.
14. Fire drills are conducted routinely and across shifts.	Three of the five staff interviewed indicated that fire drills are conducted once a month. The other two were uncertain of the times when fire drills were conducted.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well-maintained.	Observations during tours of nine residential areas indicated that bedrooms were clean, comfortable and well maintained.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of bedrooms in nine residential units indicated that all bedrooms are furnished with a mattress, sheets, blankets and a pillow.

3. Curtains or other coverings are provided for privacy.	Tours revealed that curtains or other coverings are provided for privacy.
4. Bedrooms are free of hazards such as dangling blind cords, etc.	Tours reveled that bedrooms are free of dangling cords as hazards.
5. Patients/residents are able to obtain extra covers.	Tours revealed that a linen closet is located in located in each residential unit so that residents can obtain extra covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews and observations revealed that residents have a choice on how to decorate and personalize their rooms.
Seclusion Rooms	**Comments and Observations**
1. Seclusion and/or time out rooms are clean.	Observations revealed that the time out rooms were clean.
2. Seclusion and/or time out rooms allow for constant observations.	Interviews indicated that when time-out rooms are used, which is infrequently, constant observation is required.
3. Bathrooms are located close to the seclusion or time-out areas.	Interviews and observations indicated that bathrooms are located close to time-out areas.
Bathrooms	**Comments and Observations**
1. Bathrooms were clean and well maintained	Observations revealed that overall bathrooms were clean, though the reviewer did notice two unflushed toilets and 1 very dirty sink during the tours of the nine residential units.
2. Bathrooms were noted to be odor free.	Observations indicated all bathrooms were odor free.

3. Bathrooms were free of hazardous conditions.	Observations revealed that all but two bathrooms were free of hazards. The two bathrooms that had potential hazards were as follows: Building 6B – In a hanging basket there were loose rubber gloves, a open container of petroleum jelly and a bottle of shampoo Building 7B – A latex glove was dangling out of a unlocked box in which it was stored. It should be noted that there were not any residents in the units at the time of the visits so the reviewer was not aware of the mobility and dexterity of the residents that live in the two particular units cited.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well-lit and free of hazardous conditions.	Observations indicated that pathways are free of hazardous conditions.
2. Buildings are identified and visitor procedures for entry posted.	Tours were conducted during a time in which residents were not in cottages, in addition the Director had alerted staff that OIG reviewers were on site, so no visitor procedures were employed at the time of the visit.
3. Grounds are maintained.	Tours and observations indicated that grounds are well maintained.
4. There are designated smoking areas with times posted.	Interviews with staff did not indicate that there were any residents that smoked.
5. Patients/residents have opportunities to be outside.	Interviews with staff and observations of activity on grounds did demonstrate that residents have the opportunity to be outside, weather permitting.

Other comments regarding the environment: SWVTC is currently in the process of preparing one of the cottages for implementing a regional program for persons who are dually diagnosed. The program will serve persons diagnosed with mental retardation who are also experience active symptoms of an acute mental illness from the Southwestern Virginia region who could benefit from a comprehensive assessment and short-term (less than 90 days) structured programming with the goal of successful reintegration into the community. This program will provide intensive short-term services for individuals from

the Southwestern Virginia area. Interviews indicated that the facility has a target date of beginning this program in the Fall 2003 by gradually accepting admissions until the targeted capacity of 8 residents are achieved. Members of the OIG review team were informed that SWVTC has been able to advertise for a full-time psychiatrist as a component of this regional program. A percentage of the psychiatrist time will be devoted to providing coverage for this program, but the individual will also address the psychiatric needs of other facility residents, as appropriate. Currently SWVTC has been using a part-time temporary psychiatrist to provide coverage. In addition, the review team was informed that the facility has recently advertised for a full-time doctorate level clinical psychologist and anticipates that this position will be filled within the next six to eight weeks. This person will serve as the Director of Psychology, providing clinical supervision for the Master's level psychologists at the facility. In addition, the individual will provide assessment and treatment recommendations for person involved in the regional dually diagnosed program. Utilization of bed capacity and usage will be managed by a committee comprised of members from the regional community services board, SWVMHI and the training center.

OIG Finding 3.1: SWVTC is currently finalizing plans for the opening of a regional program to address the needs of person with the dual diagnosis of active mental illness and mental retardation.

OIG Recommendation: None at this time. The OIG looks forward to reviewing this program during future inspections.

DMHMRSAS Response: Plans are being finalized for the regional Dual Diagnosis Program.

OIG Finding 3.2: Overall, the facility was noted to be clean, comfortable and well maintained. Recent improvements were noted.

OIG Recommendation: None

CENTRAL VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
JULY 11-13, 2000
OIG REPORT # 27-00

UPDATE – JULY 2003

SECTION FIVE: ACCESS TO MEDICAL CARE

Finding 5.3: Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.

Recommendation: Consider mechanisms for increasing access to the psychiatrist such that every resident currently on or in need of psychoactive medication have access to a psychiatrist a minimum of one face-to-face visit every three months.

DMHMRSAS Response: In 1991, CVTC, in order to increase access to psychiatric services for clients, entered into an agreement with Western State Hospital (WSH) for services from one of their psychiatrists. As a result of this agreement, the WSH psychiatrist spends one day every other month at CVTC to evaluate and treat clients. CVTC is initiating steps to create a second full time psychiatrist on staff. CVTC now is reviewing documentation requirements and service processes in an effort to streamline the paperwork and increase client contact time by the psychiatrist.

6 Month Status Report: 7/1/01:

CVTC created and advertised for a second psychiatrist; and at least four individuals called to make inquiries. However, as of this date, no applications have been received. There is one individual who recently indicated interest in the position and has asked for an application. The facility is hopeful.

CVTC's psychiatrist met with the Medical Director at Southside Virginia Training Center (SSVTC) on April 12, 2001 to discuss and review both documentation efforts and service processes to help determine how CVTC might streamline its documentation efforts. In addition, Dr. Jeffrey Geller, DMHMRSAS consultant, conducted a site visit at CVTC on June 28 – 29, 2001, during which he met with the facility's psychiatrist and Medical Director. He made suggestions on how to improve the service process and documentation efforts. CVTC's psychiatrist and Medical Director, after reviewing the information obtained from Dr. Geller and from SSVTC, will develop plans to move to a more effective treatment and documentation model.

OIG Comment– *Interviews revealed that the facility continues in its efforts to increase psychiatric time. The contract involvement of a psychiatrist from WSH has been discontinued due to time limitations of that individual. The facility has approached*

several local psychiatrists in an effort to replace the one day a month availability provided by that contractor but has been unsuccessful in recruiting a candidate. Some discussion occurred with several other facilities regarding the possibility of sharing psychiatric coverage but this was not successfully completed. The facility continues to operate with one full-time psychiatrist. It was noted on the date of this inspection that approximately 40% of the residents are prescribed psychotropic medications. This finding is ***ACTIVE.***

6 Month Status Report: 01/01/02
CVTC has not been successful in recruiting for a second psychiatrist. To date, only one application has been received. A psychiatrist was interviewed, but the interview panel did not recommend the applicant for hire. CVTC has been discussing the possibility of contracting with a local psychiatrist to provide services one day a month to the facility.

OIG Comment *– Interviews with administrative staff indicated that the second psychiatrist that had been hired by the facility resigned due to relocation. The facility plans to advertise in an effort to replace this individual. Interviews with a variety of disciplines and a review of records for behaviorally challenged individuals demonstrates that this facility's need for increased psychiatry time is critical. There are increased numbers of residents with dual diagnoses and complicated medication regimens. Three out of five of the records reviewed did not reflect that there was systematic method for assuring that appropriate follow-up occurs after intervention. This finding is* ***ACTIVE.***

OIG Comment (June 2003) *Interviews with administrative staff, a review of ten records for individuals on psychotropic medications and a review of six behavioral management plans demonstrated this facility's ongoing need for additional psychiatric support in addressing the needs of the residents. CVTC has requested assistance from the Central Office and the OAG in reviewing the possibility of a psychiatrist from another facility traveling to CVTC in order to support the work of the full-time staff psychiatrist. Approximately 230 residents are currently on psychotropic medications at the facility. Each person placed on these medications has a behavioral plan developed. THIS ISSUE WILL BE IMPORTANT FOR THIS FACILITY TO ADDRESS IN ORDER TO EFFECTIVELY MANAGE THE NEEDS OF THESE RESIDENTS. This finding will remain* ***ACTIVE.***

Status Report: 7/03

CVTC is pleased to report progress in obtaining additional psychiatric services. A psychiatrist has been obtained via a contract with a Locum Tenens agency on state contract. The psychiatrist will begin providing services to the facility by August 1, 2003. Initially the psychiatrist will work one to two days a month. In addition, the DMHMRSAS Workforce Development Manager will be providing CVTC with technical assistance for additional recruitment.

CVTC continues the recruitment for additional psychiatric coverage. The psychiatrist position is currently listed on the Department's "Hot Job" Website. Additionally, CVTC's Director of Procurement has contacted two agencies having the "locum tenens" state contract to determine if psychiatric services can be obtained via their agencies. Two prospective candidates from *Staff Care*, one of the contract agencies, are considering the position. *Staff Care's* recruitment department is also seeking other prospects as well. Another Locum Tenens contractor has been contacted as well to begin a search.

SECTION EIGHT: FACILITY CHALLENGES

Finding 8.2: **Recent admissions have been more behaviorally and psychiatrically complex than in the past.**

Recommendation: Residents transitioning into the community would benefit from the development of a Community Outreach Consultation Team to aid in treatment planning and implementation. This team, comprised of professionals from various CVTC disciplines, could assist community staff in the use of Applied Behavior Analysis for the development and monitoring of behavioral interventions.

DMHMRSAS Response: For mental retardation services, as well as mental health, rural communities have more difficulty obtaining and keeping staff with specialized expertise. While there are many factors contributing to this situation, a major factor is the strong economy, which creates strong competition from urban areas and from the private sector.

Applied Behavior Analysis (ABA) is a highly specialized area that has been adopted nationwide only recently. Here in Virginia, the Department began an ABA training program for facility staff just last year in collaboration with a contract with George Mason University. In FY 2002, the Department will offer this training to CSB personnel; and, although space in the course is limited, the Department can give priority to staff from rural areas.

We understand that some CVTC staff have specialized skills that either have not yet been developed, or are available only on a limited basis, in community settings. At this time we do not feel that the development of a formalized team at CVTC is necessary.

However, training center staff cannot maintain a professional treating relationship with individuals once discharged from the facility. The Department continues to encourage consultation by facility staff with community providers upon request for clients discharged from our training centers. Each training center is responsible for making the availability of such consultation known both to CSBs and to other community providers. CVTC, as in the past, will continue to make staff expertise available to communities serving clients who have been discharged in order to facilitate successful, long-term community placements.

6 Month Status Report: 7/1/01:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists have provided consultation to CSBs as requested, and recently the facility's psychiatrist provided consultation to an MH facility regarding a client's treatment.

OIG Comments – *Interviews indicated that the admissions to the facility continue to be very complex and challenging. The facility plans on enhancing behavioral management plans with the completion of the psychologist training and the recent hire of the PhD psychologists. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/01/02
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists and staff have provided consultation to CSBs as requested regarding clients who have been discharged from CVTC. CVTC is frequently the first point of contact for increasingly complex cases. CVTC staff often are able to divert admissions because of their familiarity with the state-wide array of services and are able to suggest more viable/appropriate options for individuals.

OIG Comment *– Interviews with administrative staff indicated that the facility continues to receive referrals for challenging and often complex individuals. It was noted that the facility has recently received a number of admission request for individuals who were acknowledged as challenging for the community but did not meet admission criteria. It was commented upon that this facility ranks in the top ten in the nation for having the highest census. Census reduction efforts alone will not serve to provide a reasonable method for assisting this facility in coming in line with the other facilities. It is recommended that the Central Office evaluate the distribution and placement of MR residents within the DMHMRSAS resource system. This finding is* ***ACTIVE.***

OIG Comment (June 2003) - *Interviews with administrative staff and a review of two of the three community consultations completed by members of the psychology staff over the past year demonstrated efforts by the facility in assuring that admissions to the facility*

are appropriate. CVTC receives requests for a number of admissions for persons that present as very complex and/or challenging. There have been 18 emergency admissions to the facility since the last OIG inspection. Several of these represent multiple admissions for single individuals. The census on the initial day of this inspection was 608 residents. Included within this number are two residents preparing for community placement, three residents with scheduled moves to other training centers closer to their homes, and two residents admitted for short-term admissions. At one time, CVTC was ranked number one in the nation for having the highest census. Currently the facility ranks ninth. Efforts continue towards census reduction towards the goal of the facility having an ICF-MR capacity similar to the three smaller regional training centers, which is approximately 200 residents.

Members of the psychology department have conducted several consultations for persons within the community. Even though this outreach service has the potential for being very beneficial for the consumers, one difficulty has been in the effective follow through by the community, primarily the CSBs. Without an effective way for assuring recommendations are completed, the community runs the risk of an outcome of institutional placement despite the outreach. CVTC has clearly made progress in this area, however since this remains an areas of potential difficulty for residents this finding remains ***ACTIVE****.*

Status Report: 7/03
CVTC continues to make its staff available to consult with CSBs and providers upon request for clients discharged from the facility in order to facilitate successful, long term community placements The most recent consultation was provided on July 17, 2003. CVTC staff will also continue to provide consultations to CSBs on request for persons in the community. CVTC leadership meet regularly with the HPR I and HPR III Regional Groups, at which time apparent trends in the needs of populations served as well as challenging cases are addressed.

CENTRAL VIRGINIA TRAINING CENTER
SNAPSHOT INSPECTION

MAY 16, 2002

OIG REPORT # 61-02

UPDATE JULY 2003

SECTION TWO: STAFFING ISSUES:

Finding 2.2: There is insufficient psychiatric coverage to meet the needs of residents at CVTC.

Recommendation: Prioritize the recruitment of additional psychiatric services at CVTC.

DMHMRSAS Response: DMHMRSAS concurs. CVTC continues the recruitment for additional psychiatric services. The Facility Director has also spoken with the Director of Catawba Hospital to determine the possibility of obtaining additional or shared psychiatric resources from Catawba Hospital.

OIG Comment (June 2003) *Interviews with administrative staff, a review of ten records for individuals on psychotropic medications and a review of six behavioral management plans demonstrated this facility's ongoing need for additional psychiatric support in addressing the needs of the residents. CVTC has requested assistance from the Central Office and the OAG in reviewing the possibility of a psychiatrist from another facility traveling to CVTC in order to support the work of the full-time staff psychiatrist. Approximately 230 residents are currently on psychotropic medications at the facility. Each person placed on these medications has a behavioral plan developed. THIS ISSUE WILL BE IMPORTANT FOR THIS FACILITY TO ADDRESS IN ORDER TO EFFECTIVELY MANAGE THE NEEDS OF THESE RESIDENTS. This finding will remain* ***ACTIVE.***

Status Report: 7/03
CVTC is pleased to report some progress in obtaining psychiatric services. A psychiatrist has been obtained via contract with a Locum Tenens agency. The psychiatrist will begin providing services to the facility by August 1, 2003. Initially the psychiatrist will work one to two days a month. In addition, the DMHMRSAS Workforce Development Manager will be providing CVTC with technical assistance for recruitment and retention efforts.

CENTRAL VIRGINIA TRAINING CENTER
CVTC RESPONSE TO REPORT - SITE VISIT, DEC. 4 – 8, 2000

JOINT INSPECTION: DEPARTMENT FOR RIGHTS OF VIRGINIANS WITH DISABILITIES & THE OFFICE OF THE INSPECTOR GENERAL
OIG REPORT #34-00

UPDATE – JULY 2003

SECTION TWO: FINDINGS RELATED TO STAFF

Finding 2.3: There are an insufficient number of Rehabilitation staff employees.

Recommendation: Develop a method for increasing the presence and effect of OT and PT staff at CVTC through restructuring of current workload and use of contract or external professionals to build an enhanced focus on injury prevention and safety.

DMHMRSAS Response: DMHMRSAS concurs. We are confident that the actions taken to date and in process at CVTC (see above) will increase the presence and effects of PT and OT staff. At present, within existing resources, the facility's minimal goal for each therapist is to develop one physical management plan each month. By reallocating current resources, CVTC has developed plans to recruit seven additional rehabilitation staff: two (2) OTRs; two (2) COTAs; one PT; and two (2) LPTAs. As additional therapy staff are available, staff-to-patient ratios will decrease and physical management plans will increase more quickly. Staff-to-patient ratios also will be decreased as further downsizing occurs as a result of client discharges to appropriate community settings.

In order to restructure staff workloads and to improve client safety, a pilot project on team delivery of care was initiated in Lynnhaven Center in December 2000. In this pilot program, the OT/PT staff, members of the ID team and other direct care staff all work together in an integrated fashion to carry out plans and to improve outcomes for clients. At this time, the pilot program serves 51 clients. This integrated effort has led to increased skill identification and acquisition for clients, examples of which include:

- ® twelve clients have had changes in adaptive eating equipment that enabled greater safety at meals.
- ® seven clients now regularly engage in ambulation activities outside. In addition to potential health benefits, ambulation enhances the client's capacity for community integration.
- ® Fourteen clients have demonstrated increased manipulation skills following supported positioning in side-lyers.

CVTC plans to expand this program to the rest of the facility.

CVTC continues to utilize area academic centers in order to promote development of new professionals. In March 2001, an OT Level II student completed her three-month internship at Lynnhaven center. Recently, CVTC has entered into a contractual agreement with East Tennessee State University relative to internships for Physical Therapy students. Other colleges have shown an interest in placing OT at CVTC for training, which the facility senior OT is coordinating. CVTC also is examining the feasibility of creating a modest stipend to students as an incentive in the future.

In order to further promote client safety, the facility Director has initiated, and will continue, meetings with the Director of Physical Therapy and Occupational Therapy staff to re-structure staff workloads and priorities. The Director of PT and OT Supervisor are developing new Employee Work Profiles which will be completed by June 2001.

CVTC will establish and begin recruitment of additional rehabilitation staff by July 1, 2001. The facility Director, in collaboration with the PT Director and fiscal staff, will

explore the possibility of contracting additional therapy staff. A decision will be made regarding contract staff by July 1, 2001.

6 Month Status Report: 7/1/01
CVTC advertised for the seven additional rehabilitation positions and vacancy announcements closed July 13, 2001; there are applicants for each of the positions. The facility Director, Director of Physical Therapy and designated Occupational Therapist have discussed the possibility of contracting additional therapy staff, but would prefer to have full time staff. Once new staff are added, the facility will determine if there are additional needs. Therapy staff continue to work with center level staff on the development and facilitation of physical management plans. At present, 121 physical management plans have been developed. CVTC has set aside funds to provide modest stipends in the future for level two field work students. The facility will also provide housing on campus for out of state students.

OIG Comments*- During the September 2001 follow-up inspection, it was learned that the facility now advertises the full salary range for these critical positions. One full time Physical therapist and one full time Physical therapy assistant have been added to this department. On October 10, 2001, they will re-advertise for one more of each of those positions. Two full-time Occupational Therapists have been hired; one started in September and one was still in the process. Also, two, Certified Occupational therapy assistants have been interviewed and are pending offers for employment. Additionally, in an effort to help with recruitment, the facility is offering a stipend and on-site housing for OT and PT students in need of a practicum. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/1/02

Additional positions for RPT, OTRs, LPTAs and COTAs have been advertised and interviews completed. Since September 1, 2001, two OTRs, one LPTA and two COTAs have been hired.

Rehabilitative therapy staff continue to work with center level staff on the development of physical management plans. At present, 193 physical management plans have been developed and implemented. Each therapist's Employee Work Profile includes a minimal work requirement of completing an average of two PNMPs monthly. Additional PNMP completions are encouraged. According to facility policy, clients who have the most severe PMNP needs will be identified for priority services. APMs on each living area have been provided a Client Priority Form for PNMPs.

Rehabilitation Managers have attended College Fairs in the past to attract new graduates for employment. This proved successful. An Instructor from CVTC Staff Development and Training, who handles school contracts for OT and PT, is in the process of expanding this program.

CVTC now offers an OT and PT level II Clinical Placement program with provisions for a stipend and housing on site. Information brochures and applications regarding the program were mailed in December 2001 to all colleges with whom the facility has contracts. In addition, the program information and application are on CVTC's website.

OIG Comment – *Interviews with both administrative and treatment staff indicated that the facility continues in its efforts to hire appropriate numbers of rehabilitation staff. Staff related that the additional responsibilities associated with the recent initiatives have also resulted in increased demands for tracking data, completing work-orders and other documentation requirements in a timely manner.* ***CVTC should consider providing secretarial support and additional resources for automating these work tasks as a way to offset the staffing concerns to some degree.*** *This finding is* ***ACTIVE.***

OIG Comment (June 2003) - *Interviews with members of the rehabilitation staff, and administration indicated that CVTC continues in its efforts to maintain an appropriate level of rehabilitation staffing. At the time of this follow-up review there were seventeen physical therapy positions, including five physical therapists, six LPTA positions and six rehabilitation aides. One of the therapist positions is designated for the Director position. There is also a contract therapist position included in the numbers. In the occupational therapy division, there is the Director position, 7 OTRs and 10 COTAs. Currently this division has two vacancies, one due to retirement. Plans are to replace these persons as soon as possible. Concerns were raised regarding current recruitment efforts for this level of professional, which limits advertisement to local newspapers.*

In addition, the facility has a rehabilitation engineer and three wheelchair lab technicians. Since there is little "padding" in the numbers of rehabilitative staff for this facility, absences (such as on short-term disability) and/or vacancies have a significant impact upon productivity. Caseloads have increased.

Staff had indicated that one mechanism for increasing productivity within the rehabilitation staff divisions would be through the addition of computer access and computer programming within the division. Much of the work completed could be more efficiently completed with access to technology. This would decrease the time spent on completing the necessary paperwork as well as increase communications among the divisions and the facility as a whole. Members of the OIG staff were informed by administrative staff that a number of computers had been ordered as well as the installment of the needed connections for linking the system facility-wide were underway. This finding remains ***ACTIVE.***

Status Report: 7/03

Currently, CVTC has 8 Registered Occupational Therapists and 10 Certified Occupational Therapy Assistants (filled positions). The Occupational Therapy Director is included in the number of OTRs and she implements physical management plans and completes wheelchair evaluations. An OTR was most recently hired in April of this year. There is one OTR who is currently out on short-term disability, but should be returning soon.

Currently, CVTC has six (6) Registered Physical Therapists, seven (7) LPTAs and six (6) Rehabilitation Aides. There is currently one vacant position that has been advertised nationally in the professional publication, *Physical Therapy Advance***.** Another RPT will be leaving at the end of this month. This position will be advertised nationally as well. Rehabilitation job vacancies are listed on the Department's "Hot Job" Website. This allows for individuals seeking a quick glance for vacancies to query on specific jobs such as Registered Physical Therapists/Occupational Therapists.

In addition, the Department's Office of Human Resource Development will be providing CVTC with technical assistance for recruitment and retention of both rehabilitation and other needed direct care staff. The DMHMRSAS Workforce Development Manager has been assigned to this task.

CVTC agrees that one mechanism for increasing productivity within the Rehabilitation Services Division is through the addition of computer access and computer programming within the Division. In this regard, the facility is in the bid process of Phase II of its fiber optics infrastructure. If successful, fiber will be extended to Buildings 5, 6, 7, 8, 9, 11, 12, 14 – 20, 27 and 65. With the end-of-year acquisition of new computers, CVTC is able to upgrade existing computers and to place additional computers within the Rehabilitation Services Department. Users are being added to the Local Area Network for e-mail and Internet access within buildings where the fiber optic infrastructure exists and by dial-up until fiber infrastructure reaches their building.

Finding 2.6: Some residents at CVTC have had physical management treatment programs developed.

Recommendation: Re-prioritize the effort to have a physical management plan for each resident. Consider prioritizing those who have had one or more serious injuries.

DMHMRSAS Response: DMHMRSAS concurs. CVTC has established a Physical Management Leadership (PML) team which is composed of: the physical therapy staff, center staff, the Director of Staff Development and Training, the Director of Nursing, and the Assistant Director of Program Services. This team is responsible for overseeing implementation of physical management plan development throughout the facility. The Facility Director has met with Director of Physical Therapy and Occupational Therapist to emphasize the importance of physical management development and of the need to re-prioritize our efforts in this area. The Facility Director will meet with QMRPs, APMs, and center directors relative to facility efforts in physical management and injury reduction. The Director of Physical Therapy has been directed to prioritize physical management plan development for those clients who have had a serious injury. CVTC anticipates that physical management plans for all clients in need of such a plan will be completed within the next 24-36 months, as resources allow.

6 Month Status Report: 7/1/01
Please refer to the response for Finding 2.3. As of the end of May 2001, Physical Management Plans have been developed and implemented for 121 patients.

OIG Comments*- An interview with the Director of Physical Therapy revealed that he has designed a prioritization process related to injury rates, for the development of physical management plans on each consumer. To date, 150 plans have been completed and implemented, and the staff will continue to work on these at a rate of two per month until they have been completed facility wide. From now on, the physical management plans will be updated as needed, but no less than annually along with the care plans. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/1/02
As of December 31, 2001, Physical Management Plans have been developed for 193 clients.

OIG Comment – *Interviews and the reviews of data indicated that approximately 200 physical management plans have been completed. Staff will continue to work on these at a rate of two per month until they have been completed facility wide. Physical management plans will be updated as needed, but no less than annually along with the care plans. This finding is ACTIVE.*

OIG COMMENT- (June 2003) *Interviews with administrative and treatment staff reveled that at the time of this follow-up review 320 physical management plans had been completed, in addition to the annual updates for those previously completed This staff have been working diligently over an extended period of time to address the completion of these plans within this facility. This task has remained a priority despite other demands. Even though a pattern for completion of these plans has been well established, the OIG will continue this finding as* ***ACTIVE*** *and will track progress during future reviews to assure efforts towards completion continue.*

Status Report: 7/03
CVTC staff continue their efforts in the development and implementation of physical management plans. As of July 16, 2003, 322 physical management plans have been implemented at the facility.

Finding 2.12: Staff shortages at CVTC are critical.

Recommendation: Central Office needs to work with the leadership of CVTC to address several issues related to staff shortages.

DMHMRSAS Response: DMHMRSAS concurs. Through re-allocation of current resources, CVTC plans to hire seven rehabilitation staff (please refer to our response to Finding/Recommendation 2.3). As you know, all of our facilities are being affected by the state and national nursing shortages. The Department's Office of Human Resource Development is leading a joint facility and Central Office work group to intensify our efforts in nursing recruitment and retention system-wide. In addition, CVTC has continued its own promotional and recruitment efforts, many of which were noted in our response to the Inspector General's visit of July 2000. CVTC also continues to work diligently to help clients move to less restrictive environments. As clients are discharged to appropriate community settings, CVTC will re-allocate staff in order to reduce staff-to-patient ratios. The Department made a request during the last biennium for sufficient funding to increase staffing to CRIPA levels at all the facilities, but that request was not approved.

6 Month Status Report: 7/1/01
The Department 's Director of Human Resource Development (HRD) has established a system-wide committee to address issues relative to nursing retention and recruitment at facilities. In May 2000, the Department implemented recruitment and retention bonuses for nurses. This HRD committee, which includes Directors of Nursing from the facilities, continues to monitor hiring and retention trends as well as search for additional means by which to improve recruiting and retention. Following the direction from the HRD committee, CVTC has initiated two facility projects. CVTC recently completed a salary review for its LPNs (28) relative to internal alignment. The review resulted in an in-band adjustment for 14 LPNs.

CVTC also is in the process of developing a proposal for creation of weekend shift differentials for nurses (RN & LPN). The proposal will be sent in the near future to by Central Office for approval.

OIG Comments *- Since July, CVTC has hired 46 direct care staff and has offers pending to another 22 employees. They have added a shift differential to entice second and third shift workers, especially certified nurse assistants and med aides. They have also continued to emphasize the recruitment of professional staff across disciplines, especially nursing, and psychiatry. CVTC was able to hire a Ph.D. level psychologist with Behavior analysis training experience. Administration staff has also participated in a task force including community health care workers, who are also struggling to increase efforts to recruit skilled staff. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/1/02

DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a day-long special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the state Secretary of HHS.

CVTC obtained approval for weekend differentials for nurses (RNs and LPNs) and instituted the differentials on 8/25/01. The CVTC Director of Human Resources continues to serve on the Workforce Steering Committee and attended, along with other facility staff, the December 14th Workforce Summit.

OIG Comment – *Interviews revealed that workforce issues continue to remain an issue with this facility. It was predicted that this issue will continue to be a chronic problem for this facility, particularly as a number of seasoned employees approach retirement. This finding is* ***ACTIVE.***

OIG Comment (June 2003) – *Interviews with administrative and direct care staff as well as the review of overtime data and staffing patterns demonstrated that this facility currently is able to maintain minimal staffing patterns through a variety of techniques, such as census reduction, community consults in an effort to decrease emergency admissions, and continuous recruitment. Workforce issues continue to remain a significant issue at this facility. Direct care staff, in particular, discussed their concerns regarding the availability of human resources as a number of them are approaching retirement age. This finding remains* ***ACTIVE.***

Status Report: 7/03

The Department's Office of Human Resource Development will be providing CVTC with technical assistance for recruitment and retention of both rehabilitation and other needed direct care staff. The DMHMRSAS Workforce Development Manager has been assigned to this task.

CVTC continues to actively recruit staff. At present there are 110 applications for direct care staff in various stages of processing. The facility recently hired a new Safety Director, two new Assistant Program Managers, a Nurse and Speech Pathologist. All vacant positions are listed on the Internet in "Recruit" which is accessible from any place, nationally or internationally.

SECTION THREE: FINDINGS RELATED TO FACILITY FACTORS

Finding 3.2: The population density (number of residents) per living area is high given the extent of disability in individuals currently residing at CVTC.

Recommendation: Continue to work toward this goal of ten persons per living unit.

DMHMRSAS Response: DMHMRSAS concurs. The Department has based its biennium Master Planning and Capital Requests for total renovation of the core CVTC buildings upon the goal of creating living areas of only ten clients. In addition, plans include moving all living areas to the first floor of each building whenever possible.

CVTC staff will continue to work toward the goal of ten persons per living unit through downsizing as clients are discharged into the community. CVTC is referring clients from other catchment areas to facilities closer to their homes as vacancies occur at those facilities. Although additional funds were requested of the state legislature, no new waiver moneys are available in this fiscal year. As a result, we anticipate that CVTC will have significantly fewer discharges this year. We are hopeful that the upcoming fiscal year will provide an increased opportunity for individuals to transition to the community.

6 Month Status Report: 7/1/01
CVTC continues to work towards the goal of ten persons per living area. Since July 13, 2000, 19 clients have been discharged from the facility. Currently, four clients are transitioning back to their communities and will be discharged soon. An additional 10 clients have been approved/funded for waiver services. The number of discharges has been significantly less during the past year due to changes in waiver funding/slots available.

OIG Comments *- From July 2000 to July 2001, there has been a reduction in 33 residents at the facility and administration has reduced the operating bed capacity. However, they continue to experience difficulty in placing consumers in community settings, partially due to severity of impairments, family opposition, and less community capacity. The stated goal at CVTC continues to be 10 residents per living area and they are working toward this through appropriate placement of individuals. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/1/02
CVTC continues to work towards the goal of 10 persons per living area. Since September 2001, four clients have been discharged from the facility, and currently another four clients are on leave, pending discharge. CVTC staff continue to work with family members and CSB staff on discharge planning via I.D. Team meetings and transition plans. At present, twelve clients have been approved for waiver funding. The Director of Staff Development and Training, the Assistant Director for Program Services, and the Assistant Director, Community Services, attended training provided by Dr. Jeffrey Geller, Department consultant, on the new Department Discharge Protocols, which became effective 1/02/02 system-wide.

OIG Comment *– Interviews with administrative staff revealed that the facility is continuing in their efforts to decrease living unit size through transfers and discharges. The facility has established an initial target goal of having unit sizes less than 17 people, with the ultimate goal of units housing ten or less. This finding is* ***ACTIVE.***

OIG Comment (June 2003) *- On the initial day of the inspection, the census of the facility was 608 residents. This represents a reduction of approximately 20 beds since the last OIG inspection. Included within this number are two residents preparing for community placement, three residents with scheduled moves to other training centers closer to their homes, and two residents admitted for short-term admissions. The reduction in the census has enabled the facility to configure capacity within the residential units so that living units house smaller numbers of individuals. Members of the team were informed that 70% of the residents reside on units that have 15 or fewer residents, 14% reside on units of 16 to 17 residents and 16% reside on units with 17 or more residents. This finding is* ***ACTIVE.***

Status Report: 7/03
CVTC's goal continues to be having living areas with 10 persons. The loss of waiver slots for community placement of individuals residing in Training Centers has negatively impacted CVTC's ability to reduce the census on our living areas. Given the current lack of waiver monies for client placement in the community, CVTC currently is working towards an intermediate goal of having 14 persons or less on each living unit rather than 10.

Finding 3.3: The majority of wheelchairs in use and observed at the facility by the inspection team were not optimized to fit an individual's needs.

Recommendation: Work to maximize proper positioning in appropriate wheelchairs. Outdated and dangerous wheelchairs should be eliminated.

DMHMRSAS Response: DMHMRSAS concurs. Since the December 2000 site visit, CVTC has engaged in a two-prong plan, involving assessments and staff training, to maximize proper positioning in appropriate wheelchairs. Specifically, the actions are:

Physical and Occupational Therapists continue to work on proper positioning of clients in appropriate wheelchairs. Therapists, in developing a client's PMP, will evaluate the client's seating system and will design a. system to better meet the needs of the client. Priority has been given to clients using wheelchairs who reside in Lynnhaven Center or who have deemed to be a priority by the Director of PT. The facility's goal is to have PMPs and new seating systems for the 360 clients who require a wheelchair for mobility within the next three years.

® In March 2000, the facility held a two-day workshop for all rehabilitation staff on physical management including risk factors/management of orthopedic impairments and implementation of physical management.

® In August 2000, the facility provided a two-day course for rehabilitation staff, a *Therapeutic Seating Workshop: Principles and Assessment*. In this course, therapy staff were taught a thorough, methodical approach to seating assessment that is client centered. The presenters discussed therapeutic seating principles and how to best apply them in order to determine the primary requirements of a postural support system for seated/wheeled mobility. Participants practiced evaluation techniques and simulations with clients with supervision and guidance from the instructors.

® The facility purchased a simulator chair that was utilized in the August training workshop. Use of this chair will significantly assist therapy staff in developing appropriate seating positions for clients.

The CVTC Director will ensure that therapy staff establish formal processes by which:

1.) wheelchairs are identified for replacement and removal as soon as they become outdated or dangerous; and 2.) monitoring of timely replacement and removal occurs.

6 Month Status Report: 7/1/01
Physical Therapists and Occupational Therapists are utilizing the simulator chair regularly. Training was provided to O.T.s and P.T.s on Therapeutic Seating: Principles and Assessment. CVTC sent its first request for payment of a wheelchair to DMAS, which approved the purchase of the chair. Documentation for a second chair is ready to be submitted. The Director of Physical Therapy and Occupational Therapy will be developing a formal process by which wheelchairs will be identified for replacement. The Rehabilitation Department has a priority level for wheelchair work requests to ensure that wheelchairs that are hazardous to clients' health are removed and repaired immediately.

OIG Comments *- The rehabilitation engineer at CVTC is evaluating 360 transport chairs and has done 120 as of the September follow-up review. He has also completed requested assessments on 13 regular chairs since a new referral form has been introduced at CVTC. The Director of Occupational Therapy has also obtained a simulator chair, which is helpful in designing proper positioning of consumers in their wheelchairs. This finding remains* ***ACTIVE.***

6 Month Status Report: 1/1/02
The Director of Physical Therapy has customized a wheelchair evaluation form and distributed it to all therapists. It was reviewed and discussed during PT and OT meetings. Physical Therapists and Occupational Therapists continue to assess the 250 persons who require a wheelchair for mobility. Fifty wheelchair evaluations have been completed as of December 31, 2001. The target date for completion of wheel-chair evaluations is March 2003. CVTC has begun to access special funding available from DMAS so that custom-made wheelchairs may be obtained. Through DMAS funding, two custom chairs have been received and two additional chairs have been ordered. In addition, one client has received a state-of-the-art electric wheelchair that has a computerized program enabling the client to control chair movements via switch activation controlled by head movement. Rehabilitation therapists have submitted two additional requests for custom-made wheelchairs to DMAS for funding.

OIG Comment – *Interviews and a review of the wheelchair monthly update data completed by rehabilitation staff demonstrated that the facility is making progress towards the completion of the necessary wheelchair safety evaluations. Rehabilitation staff identified a system of prioritizing work-orders that addresses the most urgent safety needs first. As the facility is still in process of completing this task, this finding remains* ***ACTIVE.***

OIG Comment – (June 2003) *As with the completion of the physical management plans, this facility has a well established process for the identification of and prioritizing the work-loads in completing wheelchair evaluations. Safety concerns are targeted for completion first with evaluations for proper fitting and individuals' needs secondary. This facility has made considerable progress towards the goal of assuring that all wheelchairs used meet the prescribed needs of the residents. This finding is* ***ACTIVE.***

Status Report: 7/03
As of July 1, 2003, 257 clients require wheelchairs for therapeutic seating and mobility/transportation. Of those, 215 have been evaluated by a rehabilitation team consisting of a Physiatrist, Rehabilitation Engineer, Rehabilitation Nurse, Registered Physical Therapist and Registered Occupational Therapist. Of those wheelchairs evaluated, 185 have received modifications or been replaced entirely. Of those 185, 49 wheelchairs were either entirely funded by DMAS or have components funded by DMAS.

SECTION THREE: ACTIVITY OF PATIENTS

Finding 3.1: Active treatment is challenging for this complex and medically fragile population.

Recommendation: Continue efforts at assuring that each person has the opportunity to engage in appropriate levels of activity in order to maintain and/or improve their current level of functioning.

DMHMRSAS Response: The Restorative Team continues to guide planning and implementing patient restorative programs. Policies and procedures for a Bowel and Bladder program and Splinting and Positioning program have been developed including staff training and Team review. Future programs include Range of Motion and Dining.

The Therapeutic Recreation Department has started using a new Die-Cut machine with patients. This machine enables patients to create many paper craft projects.

With more patients getting out of bed in specialized wheelchairs, more patients are able to go on rides or travel to outings in the facility's wheelchair lift van.

Social Services, Therapeutic Recreation, and Occupational Therapy are exploring ways to implement an Assistive Technology Program for patients. HWDMC patients may be transported to the SVTC Technology Lab when not in use by SVTC patients.

OIG COMMENT (August 2003) ***This facility continues in its efforts to maximize the degree of functioning of its patients through activities, intensive nursing interventions and the introduction of restorative programs. This finding will remain ACTIVE.***

DMHMRSAS Response:

Status Report: 09/26/03
The Department appreciates that OIG's recognition of the improvement in the provision of active treatment to our medically fragile patients at HWDMC. The facility will continue to maximize opportunities to provide activities appropriate to the functioning to the individual clients.

EASTERN STATE HOSPITAL
RESPONSE TO PRIMARY INSPECTION
SITE VISIT OF SEPT. 25-26 & OCT. 3, 2000
OIG REPORT # 31-00

UPDATE MAY 2003

SECTION ONE: TREATMENT WITH DIGNITY AND RESPECT

FINDING 1.2: Challenging placements were identified as one of the primary issues facing the human rights advocates providing services for the acute admission unit, Building 2.

Recommendation: Maintain dialogue with facility, Central Office and the community regarding issues associated with community re-integration.

DMHMRSAS Response:

6 Month Status Report: 7/1/01
Eastern State Hospital has been participating in on-going meetings with Central Office and HPR-V CSBs to resolve barriers to placement and improve the discharge planning process. Utilization review of 100% of the patients in Admission Building is being conducted weekly to identify discharge ready patients. Discharges have increased as a result of these efforts. Lengths of stay have also been reduced.

OIG Comment - *Interviews revealed that this facility continues to deal with challenges associated with being able to match patient needs with available community resources. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

ESH is implementing the new statewide Discharge Protocol by January 2, 2002. The initial hospital training has been completed and the Clinical Operations Director is working closely with Central Office to continue to improve the discharge planning process. During this report period clinical social workers previously assigned to the Hospital Community Liaison/Resource Department were reassigned to programs, with the focus on preparing patients for discharge and identifying needs to be addressed upon discharge. This action was the result of statewide implementation of the Discharge Protocol that places responsibility for discharge resource identification on CSBs. The median LOS was reduced by five days in October hospital-wide and it is currently 14 days in Acute Admissions. The Clinical Social Work Director continues 100% utilization review with the Clinical Operations Director to maintain and/or decrease LOS.

OIG Comment – Interviews indicated that the facility has demonstrated initiative in addressing difficult placement issues with respect to substance abuse and mentally retarded patients. As outlined in the status report, OIG team members were informed of increased community contact regarding placement issues and a restructuring within social work for focusing on preparing patients for discharge. These actions coupled with the initiation of the statewide Discharge Protocols by all facilities are evolving. This finding is ACTIVE.

6 Month Status Report: 07/01/02

The Clinical Operations Director meets monthly with the case manager liaisons from the nine CSBs served by ESH, the Program Social Work Directors, and Central Office staff, to problem-solve and improve the Discharge Process. The Utilization Review Coordinators and Clinical Operations Director collaborate on all U.R. denials that effect discharge. There is ongoing review of all patients in the Hospital who are clinically ready for discharge and a new computer program has been developed and is in the process of being implemented to provide daily updates on all patients regarding clinical discharge ready status. The May 2002 Management Information Systems Report showed an increase in the number of discharges from January 2002 to May 2002.

OIG Comment: (March 2003) DMHMRSAS and this facility have created a number of initiatives to address the community placement needs and other issues associated with

working with persons with these special needs when hospitalization occurs. As these initiatives continue, this finding remains ACTIVE.

Update 05/01/03
The Department appreciates the recognition of Eastern State Hospital's work with the communities to assist in increasing community placement. The Discharge Protocol continues to be used and the daily tracking of discharge ready patients is fully implemented. The discharge rate continues to increase. The majority of patients that are clinically ready for discharge are waiting for appropriate housing and/or day services. The CSB liaisons meet monthly with the ESH Clinical Operations Director and Program Social Work Directors to discuss strategies to discharge the more difficult placements. A Central Office Liaison attends these meetings. Focus is on the patients on the discharge ready list more than 30 days.

SECTION TWO: THE USE OF SECLUSION AND RESTRANT

Finding 2.2: Continuous observation of patients in seclusion is not a current practice in Building 2.

Recommendation: ESH needs to review its policy regarding seclusion and update it in terms of consistency with new departmental instructions.

DMHMRSAS Response: ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints*, is currently under revision to be consistent with Departmental Instructions and policies; and it will be finalized and implemented January 1, 2001.

6 Month Status Report: 7/1/01
ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints*, has been revised and coordinated with all required clinical committees. As required by Departmental Instruction, a draft copy was forwarded to DMHMRSAS for approval prior to implementation. Policy will be implemented immediately after Central Office review. Estimated completion date is August 15, 2001.

OIG Comment - *Interviews and observations indicated that the facility continues the practice of fifteen-minute observations of patients in seclusion instead of continuous observation. On the date of the inspection, a patient in seclusion was noted by the OIG team to be lightly tapping on the door asking if someone could "please talk to me". Although he appeared to be calm and appropriate, there was not a staff member present to observe or assist him. This practice places the patient at risk for harm and the facility at risk for liability of actions that occur while the patient is not being observed. One staff member volunteered that when the patient was in seclusion, it was the only "break" they*

had from him. Record reviews demonstrated that he was a challenging patient and often required one on one due to impulsive aggressive behaviors.
Staff indicated that delays from the Central Office in approving the draft policy governing seclusion and restraint prohibited its implementation. This finding is ***ACTIVE.***

6 Month Status Report: 1/01/02
The facility has drafted a new policy TX-450-35 has been completed and revised in accordance with the new DMHMRSAS DI. The policy has been disseminated and is currently being taught to all direct care employees.

OIG Comment – *Interviews and observations during the follow-up tour revealed that staff do not practice continual observation while patients are in seclusion. To the knowledge of the OIG, ESH is the only DMHMRSAS mental health hospital that does not practice continual observation. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
Staff members have been informed on the need to adhere to the practice of continual observation of secluded patients. We have made the changes to our policy and staff are continually monitoring seclusion and entries recorded on the patient monitoring sheets. Quality Management monitors six items on the sheets and results of the monitoring show an average of 97% of observation activities are documented on the patient monitoring sheets.

OIG Comment: (March 2003) Observations and interviews with 6 of 8 staff revealed that constant visual observation DOES NOT occur for patients in seclusion. ESH policy TX 450-35 clearly states on page 3, 8 and 9. To continue this practice in conflict with hospital policy after being continued as active for a period greater than a year is unacceptable. Documentation in the records and interviews with staff and observations provided contradictory information. This finding is ***ACTIVE.***

Update 05/01/03
ESH policy on "Emergency Use of Seclusion or Restraint" number TX450-35 states that a patient who is in seclusion must be under constant observation. Further staff in-services on the policy will be given with an emphasis on those staff and supervisors working in Building 2. There will be new computer software for monitoring seclusion and restraint initiated in July. This software will help monitor adherence to the policy. In addition there is a system-wide initiative to decrease seclusion and restraint usage that will be piloted this fall.

SECTION THREE: ACTIVE TREATMENT

Finding 3.6: Patients, dually diagnosed with both mental illness and mental retardation present a placement challenge for the facility.

Recommendation: Work with the Central Office in exploring alternate methods for meeting both the treatment and placement needs for this population.

DMHMRSAS Response: DMHMRSAS continues to develop strategies to better meet the needs of the MI/MR population. The Director of Health and Quality Care, has discussed this issue in-depth with the ESH Medical Director and with other state facility Medical Directors; and they continue to explore and disseminate best practices for treating this population. The Central Office of Mental Retardation also has provided technical assistance to both facilities and communities in addressing treatment and placement needs for the MI/MR population.

DMHMRSAS supports ESH's ongoing efforts to improve treatment for this population, which includes:

- Designating one facility social worker to work exclusively hospital-wide with the MI/MR population regarding placement issues.
- ESH treatment teams aggressively referring appropriate MI/MR patients to the Behavioral Management Committee for individualized treatment plans to address problematic behaviors, which impede patient placement in the community.
- ESH staff continuing to attend, training on the treatment and resources for this population.
- ESH Liaison Director attending monthly HPR-V meetings of the CSB MR Directors to enhance facility and CSB linkage for treatment and discharge issues.
- ESH obtaining regular consultation from, a nationally recognized MR Behavioral Consultant, as needed for specific dually diagnosed patients using tele-conference technology.

6 Month Status Report: 7/1/01

Upon admission of an MR patient, the DMHMRSAS Office of Mental Retardation, is notified via letter providing pertinent information, such as initial diagnosis on admission and results of any I.Q. testing available. A quarterly report is submitted denoting information on the above patients, including date of discharge, if applicable. Barriers to discharge continue to be aggressive patient behavior and waiver placement.

A Clinical Social Worker was assigned on January 15, 2001 to track the dually diagnosed MI/MR population, inpatient adult population, and to promote facilitation of timely and appropriate discharges by working closely with the treatment teams and MR case managers.

Facility staff attended MR training workshops, including Medicaid waiver training conducted by Behavior & Assessment Consultants. The Liaison Director and the MR/MI Social Worker have visited resource fairs to meet with service providers. The Clinical

Operations and Liaison Directors attended individual services plan training and shared information with the MR/MI social worker and CSB staff. Training enhanced the hospitals ability to identify, pursue, and secure waiver entitlements.

A monthly report is prepared listing patients, diagnoses, and discharge efforts during the reporting cycle. The Community Liaison Director attends monthly HPR-V MR Director's meetings to enhance/increase facility and community communications concerning the MI/MR population. CSB Directors now actively seek alternative placement for MR patients.

A draft agreement between the Department and the CSBs will address the screening and placement needs of clients with MI/MR diagnosis. For individuals with dual diagnosis of MI/MR, both the admitting Mental Health Facility and the region's Mental Retardation Training Center shall confer to determine which institution can best serve the individuals needs.

OIG Comment - – *Interviews indicated that this population continues to present a significant challenge to this facility. Administrative staff indicated that the majority of patients currently admitted and identified as exhibiting high-risk behaviors have both a diagnosed mental illness and mental retardation. This was also confirmed during staff interviews and record reviews. Placement continues to remain a significant difficulty because of the behavioral challenges. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

Currently ESH has 22 adult patients with a Mild to Moderate Mental Retardation diagnoses. The new Discharge Protocol should assist in providing an ongoing mechanism to track this patient population relative to discharge. The Facilities Clinical Operations Director will continue to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility.

In addition, a DMHMRSAS Central Office work-group has been established comprised of representatives of MR and MH facility directors and CO MH and MR and operations representatives to discuss strategies to address the growing population. A decision should be made by the Spring of 2002 regarding what avenues the Department will take.

OIG Comment – *Interviews with staff indicated that this continues to be an ongoing problem. The facility continues to make contact with appropriate community providers in order to foster improved placement options. Resolution of this problem will require the Central Office address resources across the state for this challenging population. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
Currently ESH has 16 adult patients with a Mild to Moderate Mental Retardation diagnosis. The new Discharge Protocol is used to provide an ongoing mechanism to track this patient population relative to discharge. The Facility's Clinical Operations Director continues to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility. In addition, a DMHMRSAS Central Office Task Force has been established, comprised of representative of MR and MH facility directors, Central Office MH and MR, and operations representatives to discuss strategies to address this growing population as well as community and CSB representatives. This Task Force has met once with the Director of the National Association for Duel Diagnoses, who provided a presentation on promising programs. The Steering Committee of that group is now meeting to identify statewide programs and to consider a Statewide conference and regional planning to address this population.

OIG Comment: (March 2003) DMHMRSAS and this facility have created a number of initiatives to address the community placement needs and other issues associated with working with persons with these special needs with hospitalization occurs. As these initiatives continue, this finding remains ACTIVE.

Update 05/01/03
The Department appreciates the recognition of the work being done at ESH with this difficult population. ESH continues to have 16 adult patients with mild to moderate mental retardation diagnoses. ESH continues to monitor these patients and works with Central Office and CSB staff to develop suitable placements. Although the number has remained fairly constant, the actual patients have changed. Of these 16, several have been admitted and replaced others who were discharged. One of the ESH Program Social Work Directors continues to meet monthly with the CSB MR Directors.

SECTION FOUR: Treatment Environment

Finding 4.2: Nursing staffs frequently work mandatory overtime to meet current staffing patterns.

Recommendation: Continue to explore alternate ways of meeting the staffing needs of the facility while lessening the amount of mandatory overtime for staff.

DMHMRSAS Response: DMHMRSAS concurs and shares this concern about reducing mandatory overtime. At this time, the Office of Human Resource Development has identified nursing recruitment and retention as a systemic issue among all our facilities.

Central Office, therefore, is developing a centralized approach to this problem in order to raise the level of our efforts in nurse recruitment and retention system-wide.

The Central Office Director of Human Resource Development, is heading a joint facility and Central Office work group for that purpose. The Director is consulting with each facility's Directors of Human Resources and Nursing Services to coordinate potential initiatives.

In addition, ESH over the past months has been active in addressing the mandatory overtime issue through creation of a "Nursing Task Force" in September. This task force focuses specifically on nursing recruitment and retention issues. Accomplishments of this Task Force thus far include:

1. Meeting with nursing staff on all three shifts at the Change of Shift reports to explain Task force goals and objectives.

2. Developed, distributed, and reviewed the results of a survey sent to all nursing staff to help address recruitment and retention. The survey sought to identify specific factors of dissatisfaction among the nursing staff as well as to identify ideas and suggestions for improvement related to retention. Completed in late November 2000, the survey identified mandatory overtime and staff scheduling as the major concerns. The Task force is actively seeking viable solutions to staff concerns.

3. Developed several committees to evaluate and make recommendations regarding key staffing issues, i.e., scheduling staff by patient acuity by program rather than by HPPD.

4. A nursing Intern Program is being developed and will be advertised in the *Virginia Gazette* and the *Daily Press* after the first-of-the year in an effort to recruit nursing students. The colleges targeted will be: Hampton University, Christopher Newport University, Old Dominion University, and Norfolk State University.

In addition, on Saturday, December 2, 2000, ESH Human Resources and the Department of Nursing conducted an Open House for Recruitment of Nursing Service Employees. On-the-spot applications were accepted, and interviews were conducted. Tours of the facility were offered to those interested applicants**.** Fifty applications were received (out of 66 attendees), and 45 staff were hired. The new hires included nine Registered Nurses, seven Licensed Practical Nurses, and 29 Direct Service Associates.

6 Month Status Report: 7/1/01
The Director of Nursing is on three task forces to seek solutions to the recruitment/retention issues that affect licensed nursing and health services care workers. Listed are efforts underway to meet our staffing needs while attempting to reduce mandatory overtime for classified nursing staff: 1. Nursing Taskforce was established March 2000.

2. Bonus for working voluntary overtime began December 2000. Lists were posted in each building began January 2001.
3. Attendance bonus for DSAs began in December 2000.
4. Pilot use of voluntary overtime to reduce number of hours of unplanned leave in Medical Services began December 2000.
5. Nursing Open Houses were held in January and April 2001. Another is planned for August 25, 2001.
6. A Referral Bonus Plan and in-band adjustment recommendations were sent to Central Office Human Resource Department for approval, June 2001.
7. Developing a partnership with Thomas Nelson Community College to provide nursing related courses on ESH campus. Anticipated beginning date of classes is in fall 2001.
8. Nurse internship program began May 2001. Four RN applicants were hired in June 2001.

The Director of Nursing is a member of the DMHMRSAS Nurses Executive Group with Central Office Human Resources Office to address recruitment and retention issues at the state level. She is also a member of the Nursing Summit Taskforces on general recruitment, retention issues and recruitment of minority nurses in Virginia. The Nursing Taskforce Committee has been disbanded and a Recruitment and Retention Committee has been established. The first meeting is scheduled for August 7, 2001

OIG Comment - – *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

The following efforts have been made to help with nursing moral and retention:

1. Meetings were held with the nurses on all three shifts at the change of shift to discuss issues impacting nursing care.
2. As a result of the Nursing Service survey, voluntary overtime is encouraged and has increased. The survey reviewed issues such as recruitment and retention and the use of overtime.
3. ESH indicated a special taskforce was developed and reviewed three acuity systems for patient care. Staffing by patient acuity continues to be explored.
4. The Nursing Intern Program for nursing school students entering their senior year resulted in the recruitment of seven (7) nursing interns into the program in June 2001. The students returned to school in August 2001. The brochures

(under revision) will be mailed to all nursing schools in Virginia in January 2002 for the summer 2002 program.

Open Houses were also held on Saturday, March 24, 2001 and Saturday, August 25, 2001 to recruit and interview for Nursing Services.

6 Month Status Report 7/01/01 Updates:

1. The attendance bonus for DSAs continues.
2. The bonus for working voluntary overtime continues.
3. The pilot use of voluntary overtime to reduce the number of hours of unplanned leave in Medical Services has been successful.
4. The Nursing Open House planned for August 25, 2001 was held and was successful in recruiting DSAs.
5. The referral bonus plan for RNs, LPNs and DSA IIs was approved.
6. The nursing taskforce has been dissolved after completing the task of reviewing the overtime and recruitment issues which are being reviewed through the statewide taskforce.
7. An RN applicant through the recruitment process was hired July 30, 2001.
8. The partnership with Thomas Nelson Community College is currently on hold. Presently the College is reviewing their program accreditations

The Recruitment and Retention Committee meeting scheduled for August 7, 2001 was canceled due to the resignation of the Director of Nursing.

However, DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a day-long special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment *- Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. Nursing staff indicated that community facilities had become increasingly competitive making working "for the state" less attractive. In addition, staff interviewed related that voluntary overtime although viewed as separate from mandatory overtime results in nursing staff working as much as 16 hours of overtime per week. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

The facility is in the process of preparing to offer two (2) courses on ESH campus in collaboration with several administrative staff members from Thomas Nelson Community College. The response has been overwhelming in terms of interest by

ESH staff. There are currently four (4) intern students from the surrounding colleges in ESH Summer Nursing Internship Program. One (1) RN who attended the Internship Program last summer has been hired. This individual was motivated to become a certified nurse's aide after completion of the program last summer and has been working as a DSA II while completing her course requirements. Although minimal, this success is as a result of the Internship Program.

Meetings have been held with nurse management to clarify the use of voluntary overtime versus mandatory overtime.

OIG Comment: (March 2003) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility had the compliment of staff present on the units as scheduled. This is accomplished through a variety of techniques including the extensive use of overtime. The facility has worked to increase the use of voluntary overtime in order to reduce frequency of mandatory overtime. ESH continues in its efforts to recruit and retain its nurses. This finding is ACTIVE.

Update 05/01/03

The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, we are offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

SECTION EIGHT: FACILITY CHALLENGES

Finding 8.1: Recruiting and retaining nursing staff has proven to be extremely difficult facility-wide.

Recommendation: Work with the Central Office in developing solutions to the overall and on-going shortage of nursing personnel at this facility.

DMHMRSAS Response: Concur. See response to Finding 4.2.

6 Month Status Report: 7/1/01
Recruitment and retention of licensed nursing staff is a nation-wide issue that we are addressing at the local and department level. See response to Finding 4.2.

OIG Comment - *– Please refer to response in Finding 4.2. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

The Human Resource Department provided the Office of Health and Quality Care in Central Office, with a notebook of studies and an update of activities to enhance recruitment of nurses at ESH. These include:

1. An In-Band Adjustment for Retention of 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.
2. ESH is collecting data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market.
3. ESH is reviewing data about RN IIs and is reviewing options at developing an In-Band Adjustment for retention.
4. The part time hourly pool of RN IIs has been enlarged from 14 and now stands at 18 FTEs.
5. RNs who retired from ESH are actively being recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to retiree homes.
6. RNs who resigned from ESH are being recruited to return.
7. A revised brochure is being presented to mail to schools of nursing in Virginia to recruit senior nursing students to summer interns at the facility in 2002.
8. LPN vacancies were placed in continuous recruit.
9. The Educational Assistance Committee has approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients. The DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a daylong special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment - *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

The Human Resource Department Central Office, has prepared a notebook of studies and an update of activities to enhance recruitment of nurses at ESH.

1. An In-Band Adjustment for Retention for 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.

2. ESH collected data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market. The new hiring range was not approved for use due to fiscal constraints.

3. ESH is reviewing data about RN IIs and wants to develop an In-Band Adjustment for retention.

4. The part time hourly pool of RN IIs has been enlarged and now stands at 18 FTEs. The hourly pool of LPNs has been expanded and now stands at 7.5 FTEs.

5. RNs who retired from ESH are actively recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to their homes. Two ESH retirees have returned as part-time hourly RNs.

6. RNs who resigned from ESH are being recruited to return with some success, i.e. re-employed four returning RNs

7. A revised brochure was mailed to schools of nursing in Virginia to recruit senior nursing students to work at ESH in the summer of 2002.

8. LPNs were placed in continuous recruit in the State Employment system.

9. The Educational Assistance Committee approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

10. Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients.

11. A referral bonus program has been instituted for RNs, LPNs and DSA IIs. Though available, no bonuses have been awarded to eligible employees for recruiting and referring new nursing staff.

OIG Comment: (March 2003) Eastern State Hospital and the CO have been working together to develop strategies for recruiting and retaining nursing staff. Because there remain significant vacancies and because the recent pressures associated with reinvestment, this finding will remain ACTIVE.

Update 05/01/03

The recruitment for nurses at ESH is a continuous process. The DMHMRSAS Office of Human Resource Development has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Providing a safe environment for the patients and staff is the priority for ESH; and this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

EASTERN STATE HOSPITAL
UNANNOUNCED SNAPSHOT INSPECTION
JULY 9-10, 2001

OIG REPORT # 46-01

UPDATE MAY 2003

SECTION THREE: STAFFING PATTERNS

Finding 3.1: The facility ensures that there are adequate numbers of staff present on each of the units.

Recommendation: Maintain staffing levels for effective patient care.

DMHMRSAS Response: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities. During this 2001-2002 academic year, Eastern State Hospital is participating in the SHARPE (named in honor of Bob and Jane Sharpe, who have given funding to the College of

William and Mary to support W&M students in working as volunteers to address compelling community needs and public issues enabling students to learn more about themselves, their world, and about the vital importance of using their skills, creativity and knowledge in an overall service to society) Community Partnership Program developed by the College of William and Mary, that is utilizing the Department of Economic to study the nationwide nursing shortage, specifically as it relates to the shortage of Registered Nurses. The goal is to develop additional strategies that include intangible issues such as job satisfaction, dignity and respect in the workplace, and actions that can be taken to improve untoward situations that exist. The possible provision of employer-sponsored childcare for employees is also under continuing study. The hospital also held Nursing Services Open Houses to attract qualified applicants.

6 Month Status Report: 01/01/02
A regular financial bonus each pay period was developed and approved at ESH for nursing staff that are willing to sign up for this voluntary overtime. It is awaiting approval in Central Office. A second bonus payment was developed for nursing staff that accumulated no unscheduled absences during each pay period. This is also awaiting approval in Central Office. No sign on bonus has been developed to improve recruitment opportunities due to fiscal constraints. The additional incentive, which was developed and approved, was a new hiring range for the RN I positions. The hospital held Nursing Services Open Houses on 12/02/00, 03/24/01 and 08/25/01 to attract qualified applicants. The December Open House resulted in the hiring of 3 RNs and 3LPNs. In March, 5 LPNs were recruited and hired. The August Open House netted 1 RN and 4 LPNs. The students from William & Mary College, who are participants of the SHARPE Community Partnership Program, have conducted the survey regarding the Nursing shortage. The data process has been completed, and the students are scheduled to work on a data analysis of this project during the Spring 2002 semester. It is anticipated that the entire project will be completed by May 2002. This possible provision of employer-sponsored childcare for employees is still being discussed at the facility as an incentive.

OIG Comment – *Interviews and a review of staffing reports demonstrated that the facility uses a variety of methods to ensure that the numerical staff to patient ratios are met. This is accomplished through the use of overtime, part-time positions and contract employees. Nursing staff related that due to the acuity of the patients that minimum staffing ratios might not provide sufficient resources for the active treatment of patients. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and is successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool

of RNs was increased. These methods have proven to be successful. The Overtime Bonus Program for nursing staff has been approved and implemented. There is insufficient data to determine whether the program will increase recruitment or retention of nursing staff. The Attendance and Unplanned Leave Program has also been approved and implemented. Again, data is insufficient at this time to determine results or effectiveness. The concept of providing childcare service is still being formulated. However, due to the geriatric center relocation plan, facility space is limited. The three major issues evidenced by the SHARPE Nursing Research Project were 1) the benefits, 2) inadequate staffing and 3) respect. The Facility Director met with the Nursing Director, Medical Director and Human Resource Director to plan intervention for the identified issues. The successful intervention included regular advertisement in the newspaper and meetings with staff who have identified issues related to respect.

OIG Comment: (March 2003) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility had the compliment of staff present on the units as scheduled. This is accomplished through a variety of techniques including the use of overtime. The facility has worked to increase the use of voluntary overtime instead of mandatory. The compliment of staffing does not always meet the patterns established by the settlement agreement, particularly in the use of RNs. ESH continues in its efforts to recruit and retain its nurses. This finding is ACTIVE.

Update 05/01/03

The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all state offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

Finding 3.2: Staffing shortage is critical for nursing.

Recommendation 3.2 A: There should be a review of current policies and practices for managing overtime to assure equity among staff.

Recommendation 3.2 B: Any new practices should be done with formalized staff input.

DMHMRSAS Response 3.2 A: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities.

6 Month Status Report: 01/01/02

A regular financial bonus each pay period was developed and approved at Eastern State Hospital for nursing staff that are willing to sign up for voluntary overtime as well as a second bonus payment for nursing staff that accumulate no unscheduled absences during each pay period. This has been forwarded to Central Office for approval. There were no sign on bonus developed to improve recruitment opportunities at present. The additional incentive, which was developed and approved, was a new hiring range for RN staff.

As an effort to work on the Nursing shortage statewide the DMHMRSAS Central Office is addressing work-force needs through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. The committee met on December 14, 2001 and sponsored a daylong special meeting, Charting the Course, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the sate Secretary of Health and Human Services.

OIG Comment - *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

Mandatory overtime is utilized as a last option. However, patient and staff safety is the facility's top priority. With an increase in census, efforts were minimized to eliminate mandatory overtime. Staffing needs of units are carefully evaluated to reduce mandatory overtime. The agency has experienced some success with

recruitment. The state salaries are not competitive with the private sector, especially with limited funds for annual pay increases. The Nurse Staffing Committee meeting format was changed. Each program's Nurse Manager meets with the nursing staff assigned to the program to problem solve the staffing issues related to coverage. This method allows more autonomy for the Nurse Managers to problem solve the staff shortages utilizing input from the staff involved. (An example of this is, the staff in the admission's program agreeing to pilot the Baylor Plan.) The psychosocial program does alternative scheduling to accommodate staff needs and providing nursing coverage for the units. (An example of this is, allowing staff to work weekends and have other days off during the week.) These are examples of meeting the staffs' needs as well as meeting the nursing coverage for the unit, resulting in a "win", "win" situation.

NO OIG REPONSE

DMHMRSAS Response 3.2 B: All new recommendations and ideas have been developed through the utilization of a formalized Nurse Staffing Committee, consisting of key management and line staff that have both the knowledge of current conditions and the ability to effect significant and successful change.

6 Month Status Report: 01/01/02

A formalized Nurse Staffing Committee reviews recommendations and ideas to effect significant and successful change. The Committee is examining the impact of the work environment on retention and is promoting a more positive image of Nursing Services throughout the facility. The Committee is also addressing other work related variables including work conditions, workload, and scheduling flexibility. Exit interviews are being reviewed to identify major factors of employee dissatisfaction.

OIG Comment - *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

Nurse staffing committee meetings have been conducted within the buildings showing the highest use of mandatory overtime. Additional improvement is being made. This involves more evenly distributing staff across the shifts, and increased

utilization of 12 and 16-hour shifts, where preferred. In addition to this, other alternative strategies are being considered, i.e. some staff prefers working more weekends than weekdays. The staff morale is currently of high priority for nurse management, with feedback from the clinical nursing staff. Where possible, interventions for corrections are being put in place. Mandatory overtime is currently under consideration by the American Nurse's Association.

ESH has expanded Internet posting of jobs.

The Admission's Unit will pilot the Baylor Plan for one (1) year and then evaluate the use of this plan. **The Baylor Plan** provides Eastern State Hospital with the ability to offer a scheduling option to attract and retain Registered Nurses to work weekends. All Registered Nurse II positions are designated to be used for the Baylor Plan. Registered Nurses (RNIIs) on the Baylor Plan will work three (3) 12-hour shifts over their scheduled weekend – Friday, Saturday, Sunday or Saturday, Sunday, Monday. For the 36 hours worked they will be paid for 40 hours and receive full state benefits.

OIG Comment: (March 2003) Interviews with administrative staff, a review of staff schedules and observations on the units revealed that this facility continues to experience difficulty in maintaining the agreed upon requirements in the settlement agreement of one RN per unit per shift. The facility continues in its efforts to recruit and retain nursing personnel. Administrative staff indicated that additional shifting in nursing personnel may occur as a result of the current plan as outlined under the re-investment process, which proposes to close the acute admissions unit (Building 4). This finding remains ACTIVE.

Update 05/01/03

See response to Finding 3.1.

Although the complete plans of the proposed reinvestment initiative are not yet determined, it is hoped that the RNs from the proposed program closures will be transferred into vacant positions in order to improve the RN staffing ratio in other programs.

EASTERN STATE HOSPITAL
SNAPSHOT INSPECTION
JANUARY 9-10, 2002
OIG REPORT # 53-02

UPDATE MAY 2003

SECTION ONE: GENERAL CONDITIONS

Finding 1.1: Overall the physical environment of the Hancock Center was clean and comfortable, with evidence that effort has been made to decrease the institutional appearance.

Recommendation: Continue to promote efforts that result in softening and personalization of this harsh institutional setting.

DMHMRSAS Response: Eastern State Hospital will continue its ongoing efforts to personalize and promote a home-like environment. Purchasing, in collaboration with Clinical Leadership in Hancock Geriatric Treatment Center, continues by shopping catalogs for safe and appropriate accessories and decorations for the Geriatric clients.

6 Month Status Report: 07/01/02
Eastern State Hospital continues to enhance the therapeutic environment for geriatric patients. (Renovations to Building 28, 29, & 30 along with planned construction of a new geriatric activity building (Building 31), and the subsequent move of all patients from the Hancock Center must be considered when planning additional changes within the existing buildings in Hancock.) Requirements for the renovated facilities are currently being identified and consolidated for a funding request to the 2003 session of the Virginia General Assembly that will represent the balance of dollars that will be necessary to complete the geriatric relocation project.

OIG Comment: Tours of the facility during the March 2003 inspection revealed that the facility has made some efforts to make the buildings that currently house the geriatric patients appear less institutional. As noted in the DMHMRSAS response, this facility has established a plan that includes the closing of the current configuration of buildings used as the geriatric treatment center and moving the services to buildings that still need to be renovated. As plans have not been finalized, this finding remains ACTIVE because of environmental concerns associated with the potential move.

Update 05/01/03
DMHMRSAS has completed the necessary form (CC-2) and is selecting an architect. An appropriation of $4.6 million has already been made; and the request for an additional $11 million will be presented to the 2004 session of the General Assembly by Governor Warner. Funding will be provided through a public-private partnership with a lending institution. In the meantime, efforts will continue to maintain a therapeutic environment.

SECTION TWO: PATIENT ACTIVITY AND ACTIVE TREATMENT

Finding 2.2: Active therapeutic treatment options for lower functioning geriatric patients were minimal.

Recommendation: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatrics Treatment Center and all discipline supervisors will ensure groups/activities are conducted according to the schedule, according to group objectives, and content as outlined in the specific program descriptions and based upon the patients' interests and needs. Monitoring of the process will be accomplished daily utilizing the Visual Patient Contact Application (VPCA). This is a computerized system, which measures time spent with patients related to structured treatment activities. Supervisors will review patient participation to identify patients who may be underserved through the group process and who may benefit from more individualized attention. The GAP subcommittee will oversee and coordinate these efforts through its monthly meetings and findings will be reported to clinical leadership.

6 Month Status Report: 07/01/02
Eastern State Hospital HGTC Clinical Leadership Team has developed a more comprehensive and complete review of active treatment activities with and for the lower functioning geriatric patients. Staff education is planned to increase staff's knowledge of and ability to articulate the daily active treatment that is occurring.

OIG Comment: (March 2003) During this inspection, there was little evidence that programs for the lower functioning patients had been implemented. Activities did not occur as scheduled. A majority of staff members could not identify scheduled activities much less determine whether the groups were available. In some cases, they could not even locate a current schedule. Observations demonstrated that activities were not an entrenched part of services offered this population. Plans as outlined in the 7/02 status report have not been effective in resolving this issue. This finding remains ACTIVE.

Update 05/01/03
ESH will in-service staff on the location of the individual patient schedules and the GAP/IGAP Master Schedule. ESH will further in-service staff on activities and active treatment, their similarities and their differences. Staff requiring GAP training will be identified and training dates established. Programs that are unit specific to a ward will be highlighted on the Master Schedule. All disciplines will honor program contracts that allow rehabilitation staff opportunities for increasing programming for the lower functioning patients. This has been identified as an area of concern by the GAP sub-committee and discussed with Clinical Leadership.

Finding 2.3: Late afternoon and early evening activities in Building 34 were not taking place as scheduled.

Recommendation: A review of the active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatric Treatment Center will assess afternoon and evening patient care needs and routines. They will communicate the schedule and expectations to all staff. The treatment teams will identify relevant active treatment interventions for individual patients to improve function, or reduce loss of function. The estimated completion date for assessing the needs and identifying the interventions is May 31, 2002. Current scheduled GAP groups end by 3:00 p.m. Evening programming, when scheduled, begins at 6:00 p.m.

6 Month Status Report: 07/01/02
Ongoing the facility does a complete review of the overall program and patients' daily schedule by the Clinical Leadership Team and GAP Subcommittee. This ensures that programs are occurring as scheduled and not conflict with individual patient care related activities. A Master Schedule revision is currently being developed for implementation in July 2002.

OIG Comment: (March 2003) Please refer to response for Finding 2.3.

Update 05/01/03
ESH will remind staff that everyone is responsible for active treatment with the patient. Each staff will review the section on active treatment in the program manual. ESH will further inform staff that 1:1 programming for the low functioning patient is provided in addition to the regular posted GAP/IGAP schedules. This intervention is provided during "non-program" times to prevent conflicts with the posted schedules and/or other components of the patients' active treatment. Please refer to the response for Finding 2.2.

Finding 2.4: Records reviewed reflected limited documentation linking treatment needs to discharge readiness and the justification for continued hospitalization.

Recommendation: Promote better utilization of the clinical talent participating in the treatment planning conferences. Improve concentration by the teams on issues related to preparation of patients for discharge, as evidenced in the records.

DMHMRSAS Response: To promote improved utilization of the clinical staff's participation in treatment planning conferences, the HGTC program is implementing a computerized treatment planning system (Vista Care), which will reduce the

overemphasis on the completion of forms. Vista Care requires the development of plans for particular patients based on triggered areas of the MDS (minimum data sets). This would be beneficial to both higher and lower functioning patient groups. In addition, the recently implemented use of the "Needs upon Discharge" form will not only add to the consolidation and streamlining of paperwork, but will better focus the team's efforts on resolving discharge barriers in a more expedited fashion.

6 Month Status Report: 07/01/02
The program implemented was incorrectly identified as Vista Care when in fact, it is the VistaKeane System. As of June 13, 2002 the percentages of care plans entered into the VistaKeane System are: Building 4: 100% completed; Building 32: 95% completed; Building 34: 25% completed; Building 36: 100% completed Average HGTC/Medical Services: 80% completed {164 out of 206 completed} Building 32 will be 100% complete by June 28th. Building 34 will maintain its 2 plans per week implementation process. It is envisioned that by training more RNs (8) in computerized care plans, the efforts of MIS (new hardware and improved computer lines throughout HGTC) and patient transfers from B-32 with computerized care plans, all patient care plans will be computerized in HGTC. Estimated completion date for computerization of all plans is October 1, 2002.

OIG COMMENT: (March 2003) A review of 5 records revealed that improvements had been made in the documentation regarding linkages between assessments and discharge readiness. Progress notes outlining reasons for continued hospitalization, in general, lacked sufficient details for adequate justification. This finding remains ACTIVE.

Update 05/01/03
ESH will have the HGTC Clinical Leadership review this finding and will in-service all HGTC professional staff on the requirement to adequately enter progress notes justifying reasons for continued hospitalization.

SECTION THREE: STAFFING PATTERNS

Finding 3.1: Staffing shortages are critical for nursing services in the Hancock Center.

Recommendation: Administrative and clinical leaders must seriously re-evaluate the mission and model for the goals of serving the geriatric population. Increase staffing levels as needed for active, effective patient treatment rather than basic patient care if this is determined to be the treatment goal for the Hancock Center.

DMHMRSAS Response: The assessment of the recruitment and retention of nursing staff is ongoing. Recruitment of nursing staff in Hancock Geriatric Treatment Center (HGTC) is difficult, in part, due to the required physical work involved with geriatric population. However, the staff that work in this area desire to do so. Through contract nursing staff are utilized, few of them desire to work with the geriatric patients. The above conditions often contribute to the need for mandatory overtime. There is a system in place for this and has been reviewed with the nursing staff. There is a mandatory overtime list, however, voluntary overtime is utilized first as well as hourly and contract staff. When these options are not possible, mandatory overtime is required. Once the nurse works overtime, his/her name goes to the bottom of the list.

Despite the above issues, the Nursing Department continues to recruit and retain nursing staff with strong support from our Human Resources Department. Since December 2001, we have hired eight (8) DSA's and one (1) LPN for duty in geriatrics. Additionally, two (2) Registered Nurses have been offered positions. Recruitment and retention is ongoing at ESH.

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and has been successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. This method continues to be utilized with some success.

OIG Comment: (March 2003) Interviews with administrative staff, a review of staff schedules and observations on the units revealed that this facility continues to experience difficulty in maintaining the agreed upon requirements in the settlement agreement of one RN per unit per shift. The facility continues in its efforts to recruit and retain nursing personnel. Administrative staff indicated that additional shifting in nursing personnel may occur as a result of the current plan as outlined under the re-investment process, which proposes to close the acute admissions unit (Building 2). This finding remains ACTIVE.

Update 05/01/03
The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways

the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all state offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

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EASTERN STATE HOSPITAL
SNAPSHOT INSPECTION

JANUARY 9-10, 2002

OIG REPORT # 53-02

UPDATE MAY 2003

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2002.

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Update 05/01/03

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Building 32 will be 100% complete by June 28th.

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SECTION THREE: STAFFING PATTERNS

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OIG Comment: (March 2003) Interviews with administrative staff, a review of staff schedules and observations on the units revealed that this facility continues to experience difficulty in maintaining the agreed upon requirements in the settlement agreement of one RN per unit per shift. The facility continues in its efforts to recruit and retain nursing personnel. Administrative staff indicated that additional shifting in nursing personnel may occur as a result of the current plan as outlined under the re-investment process, which proposes to close the acute admissions unit (Building 2). This finding remains ACTIVE.

Update 05/01/03
The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff. The budgetary constraints felt by all state offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible. Although the complete plans of the proposed reinvestment initiative are not yet determined, it is hoped that the RNs from the proposed program closures will be transferred into vacant positions in order to improve the RN staffing ratio in other programs.

MARCH 6, 2001
OIG REPORT # 39-01

UPDATE JULY 2003

SECTION THREE: STAFFING

Finding 3.1: Given the degree of impairment of the individuals residing within this facility, Southeastern Virginia Training Center has an inadequate ratio of direct care and professional staff to residents.

Finding 3.2: The facility currently contracts with a local psychiatrist for 20 hours per month.

Finding 3.3: There is considerable use of overtime at SEVTC.

Recommendation: None immediate. This is a longstanding problem that deserves more close study. The facility was designed, funded and staffed for a much less impaired population than currently resides there. This, combined with current low unemployment rates in Virginia further compounds the recruitment and retention of an enduring direct care workforce. The impact of the current level of staffing at SEVTC and SWVTC that has a similar situation will be the subject of future of OIG review.

DMHMRSAS Response: We concur. The Department plans to request funds for additional staffing and other needs for SEVTC during the up-coming legislative session. In the interim, a Quality Improvement Plan Committee, comprised of Central Office and SEVTC staff, was convened to evaluate SEVTC's staffing ratios, programs, and services. A subcommittee, led by the DMHMRSAS Medical Director, along with the assistance of CO Human Resources and SEVTC staff, was formed to conduct an analysis of the Psychiatrist functions and duties to estimate the number of psychiatrist work hours needed for improved medical care and treatment provided to SEVTC's residents. SEVTC will continue to make appropriate, timely discharges and redeploy staff to critical areas. SEVTC will also continue to hire direct care positions, within the parameters of its current budget allocation. The Central Office will routinely review budget expenditures for purposes of determining opportunities for increasing direct care ratios within appropriations.

6 Month Status Report: 01/01/02
The special Training Center allocation provided in 2001 to SEVTC helped to increase psychiatric and other essential clinical services and to increase direct service staffing. A gradual reduction in overtime is expected as the direct service staffing level increases.

OIG Comment *- Interviews revealed that the facility has increased the number of psychiatric hours with the special training center allocation. The facility is currently in the process of advertising and hiring additional direct care staff members but at the time of this February 2002 follow-up, that process had not been completed. Interviews with direct care staff related that overtime continued to occur but with less frequency in the past few months. According to the OIG monthly facility data monitoring report, the overtime hours of March 2002 are significantly less than January and February 2002. Because this has not been sustained for several months, this finding remains* ***ACTIVE.***

OIG Comment: (May 2003) *Interviews with administrative staff revealed that the facility continues to actively recruit for direct care staff. A member of the human resources department has organized a job fair, which is scheduled for June. Persons interested in direct care positions will be able to be interviewed during that event eliminating the need for a return visit solely for that purpose. The downturn in the economy has resulted in an increased number of applicants. However, with increased competitors offering health benefits in the community, the previously more attractive benefits package offered by the state has lost its edge in the market, making salary more of a focus for individuals seeking employment. SEVTC utilized the specially allocated funds to the hiring of direct care staffing but also to increase medical and other professional staff. The facility hired a full-time primary care physician and increased psychiatric time from approximately 16 hours a month to 12-18 hours per week. This increase has enabled the psychiatrist to devote more attention to the residents, have increased contact with the ID teams, and be increasingly involved in meetings relevant to the management of persons with behavioral disorders.*

In addition, SEVTC has hired an evening shift supervisor. This position allows for a more effective utilization of staff, which has decreased some of the use of overtime. An additional person is scheduled to be hired in order to support the work of the supervisor, which will further enhance the effective deployment of staff during the evening and night shifts. SEVTC has made considerable progress in each of the areas identified in the findings noted above. These findings will remain ACTIVE as efforts are on-going in order to assure that resources vital in maintaining these efforts are enduring.

Status Report: 06/03
The OIG comments note several situations that have assisted with recruiting and retention. The Center held an open house/job fair on Tuesday June 10. The event was quite successful. Approximately 175 prospective applicants attended and a majority of these were interviewed for available positions. Recruiting at the job fair focused on direct service positions for residential cottages, but applicants were also interviewed for health services, security, housekeeping, and vocational programs positions. At this time the Center is evaluating individual applications and interviews, seeking references, and preparing to make a number of job offers. It is not possible to report outcome in terms of successful hires at this time; however, the Center is optimistic based on the quantity and overall quality of applicants. Center staff members who participated in the job fair have suggested repeating the event periodically, assuming that hiring outcomes are positive.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
MAY 29-31, 2001
OIG REPORT # 44-01

UPDATE JULY 2003

SECTION EIGHT: FACILITY CHALLENGES

Finding 8.1 The majority of staff interviewed indicated that shortages in direct care staff poses the greatest challenge for providing quality care to residents of the facility.

Recommendation: **Continue to explore options for recruiting and retaining staff in these key positions.**

DMHMRSAS Response: Concur. SEVTC will continue its recruitment and retention efforts for direct service staff members, professional staff, and qualified therapy assistance (COTAs, LPTAs, psychology assistants.). Current staff efforts include ongoing advertisement, flextime, shift differentials, and continuing education scholarships.

6 Month Status Report: 01/01/02
Since the last report the Center has run a more extensive advertisement campaign which has produced more applications for positions. The advertising budge has increased by 50% and advertisements appear in newspapers weekly in larger block form. A link has been for job searchers on the SEVTC website regarding current position openings. Relationships have been established with the local Navy bases regarding SEVTC openings and job posting are given to persons exiting military though TAP classes. VEC and community college posting continue.

OIG Comment – *Interviews with supervisory staff indicated that the facility has made a concerted effort at securing more direct care staff. As noted in the progress report, advertising has been expanded and a greater applicant pool noted as a result. The facility has not completed the hiring of these positions and it is for this reason this finding remains* ***ACTIVE.***

OIG Comment: (May 2003) *Interviews with administrative staff revealed that the facility continues to actively recruit for direct care staff. A member of the human resources department has organized a job fair, which is scheduled for June. Persons interested in direct care positions will be able to be interviewed during that even eliminating the need for a return visit solely for that purpose. The downturn in the economy has resulted in an increased number of applicants. However, with increased competitors offering health*

benefits in the community, the previously more attractive benefits package offered by the state has lost its edge in the market, making salary more of a focus for individuals seeking employment. These findings will remain ACTIVE as efforts are on-going in order to assure that resources vital in maintaining these efforts are enduring.

Status Report: 06/03
The OIG comments note several situations that have assisted with recruiting and retention. The Center held an open house/job fair on Tuesday June 10. The event was quite successful. Approximately 175 prospective applicants attended and a majority of these were interviewed for available positions. Recruiting at the job fair focused on direct service positions for residential cottages, but applicants were also interviewed for health services, security, housekeeping, and vocational programs positions. At this time the Center is evaluating individual applications and interviews, seeking references, and preparing to make a number of job offers. It is not possible to report outcome in terms of successful hires at this time; however, the Center is optimistic based on the quantity and overall quality of applicants. Center staff members who participated in the job fair have suggested repeating the event periodically, assuming that hiring outcomes are positive.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
FEBRUAR 17-18, 2002
OIG REPORT # 54-02

UPDATE JUNE 2003

SECTION TWO: STAFFING

Finding 2.1: Staffing numbers were at the minimum required level.

Recommendation: Review staffing deployment to assure that patterns meet the level of supervision necessary to safely manage basic body functions as well as provide for active treatment needs of the residents.

DMHMRSAS Response: Deployment will be reviewed as new positions are added utilizing new funds. Recruitment for cottage staff positions has commenced. The facility will assure that staff are deployed to meet Medicaid minimums and to address acuity in the various cottages.

OIG Comment (May 2003) – *Tours of residential units indicated that staffing patterns within the units met the minimum requirements established by the facility. SEVTC has added an evening supervisor position, which enables a review of scheduled staffing so*

*that deployment can occur without the unnecessary use of overtime. Efforts at hiring additional direct care staff continue at this facility. A job fair has been scheduled for June is an example of these efforts. This finding will remain **ACTIVE** as efforts are on-going in order to assure that resources vital in maintaining these efforts are enduring.*

Status Report: 06/03
Recruiting and retention efforts remain an on-going priority. As noted by the OIG, planning for an open house/job fair was underway at the time of the visit. The job fair was held on Tuesday June 10. The event was quite successful. Approximately 175 prospective applicants attended and a majority of these were interviewed for available positions. Recruiting at the job fair focused on direct service positions for residential cottages, but applicants were also interviewed for health services, security, housekeeping, and vocational program positions. At this time the Center is evaluating individual applications and interviews, seeking references, and preparing to make a number of job offers. It is not possible to report outcome in terms of successful hires at this time; however, the Center is quite optimistic based on the quantity and overall quality of applicants. Center staff members who participated in the job fair have suggested repeating the event periodically, assuming that hiring outcomes are positive.

SOUTHWESTERN VIRGINIA TRAINING CENTER
PRIMARY INSPECTION REPORT
APRIL 24-26, 2001
OIG REPORT #43-01

UPDATE – JULY 2003

SECTION THREE: TREATMENT ENVIRONMENT

Finding 3.7: There is a shortage of key staff in several key professional positions.

Recommendation: Review staffing patterns and functions to determine optimal levels required to effectively implement and follow-up on active treatment needs of the residents and provide adequate supervision of staff for optimal facility operations. This may not be able to be enhanced effectively without an increase in staffing.

DMHMRSAS Response: SWVTC has hired temporary and part-time employees instead of permanent employees, utilized non-direct care employees in service provision, kept other than direct care service positions vacant in order to generate funds for direct service, lowered direct care coverage when client safety allowed and consolidated supervision / managerial duties to create additional direct care staffing. All of these efforts and many others have been helpful, but not adequate to meet all staffing needs. The facility continues to review staffing patterns and utilization to determine optimal

level based on their current staffing levels. Plans identifying SWVTC staffing needs to meet NVTC/DOJ levels have been submitted to Central Office by the facility with its last submission on July 24, 2001.

6 Month Status Report: 01/01/02
Additional one-time funds have resulted in improvements in HCSW's staffing patterns. SWVTC is in the process of attempting to hire a Family Nurse Practitioner and Two RN's.

OIG Comment - *Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
A Family Nurse Practitioner has been hired to support the work of the physician. In addition, two additional nurses have been hired and will begin work in June 02. The facility believes they will be able to add a .5 FTE activity therapist at the start of the fiscal year and are hoping to find the funds to add a full time Ph.D. Psychologist.

OIG COMMENT (September 2002): ***Interviews with administrative staff indicated that the facility continues to prioritize the hiring of additional staff as funding allows. After securing additional direct care staff with the additional funds this facility received in 2001, SWVTC placed a priority in securing a family nurse practitioner to assist with the oversight and provision of primary medical care within the facility. This person has been hired and has made significant contributions to the care of the residents in a relatively short period of time. Other priorities have been established but not realized to date. This finding remains*** *ACTIVE.*

Status Report: 10/02
The positions created in FY 02 have been and remain filled. Other priorities will be met as funding allows. The recent budget reductions will clearly have some negative impact on the facility's ability to continue the staffing enhancement process.

OIG Comment (June 2003) – *Members of the OIG review team were informed that SWVTC has been able to advertise for a full-time psychiatrist as a component of a regional dually diagnosed program slated for opening in the Fall. The program will*

serve persons diagnosed with mental retardation who are also experience active symptoms of an acute mental illness from the Southwestern Virginia region who could benefit from a comprehensive assessment and short-term (less than 90 days) structured programming with the goal of successful reintegration into the community. A percentage of the psychiatrist time will be devoted to providing coverage for this program, but the individual will also address the psychiatric needs of other facility residents, as appropriate. Currently SWVTC has been using a part-time locum tenens psychiatrist to provide coverage. In addition, the facility has recently advertised for a full-time doctorate level clinical psychologist and anticipates that this position will be filled within the next six to eight weeks. This person will serve as the Director of Psychology, providing clinical supervision for the Master's level psychologists at the facility. The individual will provide assessment and treatment recommendations for person involved in the regional program. This finding will remain ***ACTIVE*** *until, the position has been filled and coverage stabilized.*

Status Report: 7/03
Recruitment for both positions is on going and will continue until they are filled. Both positions require advanced professional degrees. The date when the positions will be filled is unknown at this time.

Finding 3.8: The facility has used the combining of several key administrative positions in orders to stretch resources.

Recommendation: SWVTC work with Central Office in reviewing this practice to assure effective coverage of key functions, particularly the supervision of staff.

DMHMRSAS Response: SWVTC will continue to review utilization of current staff, however, direct care staff receives priority in recruitment and hiring. In 2000, SWVTC reorganized its staff responsibilities to create the positions as indicated through its collaborative reviews with DMHMRSAS. Reorganization allowed them to designate one staff person as a full time Risk Manager and one person to provide part of his time to complete Abuse/Neglect investigations. They have also consolidated supervision in the residential living units that allowed them to hire a Physical Therapist, a Physical Therapist Assistant, an Occupational Therapist, and an Occupational Therapist Assistant. These changes have resulted in improvements in their risk management program, abuse/neglect investigation process, physical and occupational therapy.

6 Month Status Report: 1/01/02
The facility has hired a Nurse Practitioner. The Nurse Practitioner will begin employment in February and she will assume the role of Director of Nursing, which will relieve the Medical Director.

OIG Comment - *Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the*

facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is ***ACTIVE.***

6 Month Status Report: 07/01/02
A Family Nurse Practitioner and two additional nurses have been hired. The FNP supports the work of the physician and serves as Director of Nursing. If the facility is to find funds for a Ph.D. Psychologist, this position will have a resident caseload and serve as Director of Psychology.

OIG COMMENT (September 2002): Interviews with administrative staff indicated that the facility continues to prioritize the hiring of additional staff as funding allows. After securing additional direct care staff with the additional funds this facility received in 2001, the facility placed a priority in securing a family nurse practitioner to assist with the oversight and provision of medical care within the facility. This person has been hired and has made significant contributions to the care of the residents in a relatively short period of time. Other priorities have been established but not realized to date. This includes the hiring of a PhD psychologist, which is referred to in OIG Report #68-02. This finding remains ACTIVE

Status Report: 10/02
Please see response to Finding 3.7 above. Now that HSCW, FNP, and Nursing staffing priorities have been met, additional staffing enhancements will be made as resources allow. The next priority in this enhancement process is the hiring of a Ph.D. Psychologist to serve as Director of Psychology.

OIG Comment (June 2003) – *Interviews revealed that with the anticipated hiring of the psychiatrist and the clinical psychologist that some additional shifting of administrative responsibilities can occur as happened with the hiring of the family nurse practitioner. This finding will remain* ***ACTIVE*** *until these positions can be hired and duties defined within the facility.*

Status Report: 7/03
See 3.7 above

SECTION TWO: STAFFING ISSUES

Finding 2.4: Review of five charts revealed that there has been considerable gap in access to a psychiatrist.

Recommendation: This gap in access to a psychiatrist should be brought to the attention of the Central Office so that assistance for this situation can be addressed through the state facility medical directors.

DMHMRSAS Response: SWVTC gap in psychiatric services was brought to the attention of the Central Office Medical Director. SWVTC has an addition of contracts for the services of two psychiatrists, services are being provided and clients are seen in a more timely manner. If the situation were to recur, the Central Office will be notified again. With two psychiatrists under contract, a backup should be available even if one of the psychiatrists was unable to provide service.

6 Month Status Report: 07/01/02
The two contract psychiatrists have been coming to SWVTC on a regular basis, there has not been a repetition of the service gap noted during the last IG visit.

OIG COMMENT (September 2002): *Interviews revealed that there had been some changes in the provision of psychiatric coverage by psychiatrist within this facility. This is an important concern and as such was re-noted in the most recent inspection report (OIG SS#68-02). This finding remains* ***ACTIVE***

Status Report: 10/02
The facility continues to attempt to increase the number of on-site psychiatric hours of service. Discussions are on going with several potential providers with the goal to provide at least 16 hours of on-site service per month.

OIG Comment (June 2003) – *Members of the OIG review team were informed that SWVTC has been able to advertise for a full-time psychiatrist as a component of a regional dually diagnosed program slated for opening in the Fall. The program will serve persons diagnosed with mental retardation who are also experience active symptoms of an acute mental illness from the Southwestern Virginia region who could benefit from a comprehensive assessment and short-term (less than 90 days) structured*

programming with the goal of successful reintegration into the community. A percentage of the psychiatrist time will be devoted to providing coverage for this program, but the individual will also address the psychiatric needs of other facility residents, as appropriate. Currently SWVTC has been using a part-time psychiatrist on a short-term contract to provide coverage. This finding will remain ***ACTIVE*** *until, the position has been filled and coverage stabilized.*

Status Report: 7/03
Recruitment for the position is on going and will continue until the position is filled. The position requires an advanced professional degree. The date when the position will be filled is unknown at this time.

SOUTHWESTERN VIRGINIA TRAINING CENTER
SNAPSHOT INSPECTION
September 11, 2002
OIG REPORT #68-02

UPDATE JULY 2003

SECTION TWO: STAFFING ISSUES

Finding 2.4: The number of on-site hours of service provided by the psychiatrist per month has decreased.

Recommendation: Central Office review the possibility of utilizing psychiatric staff from SWVMHI or other sources as a part of their job function to provide coverage at this facility until permanent solutions are available.

DMHMRSAS Response: The Medical Director, Office of Health and Quality Care, and Central Office management have been monitoring the psychiatric needs of all Training Centers on an on-going basis. SWVMHI is willing to "share" psychiatric staff whenever its resources allow, but that has not been possible recently. Various options are being explored. Discussions are underway about shifting psychiatric resources from the mental health facilities to the Training Centers as psychiatric services are moved to the community as part of system re-investment initiative. Availability of other psychiatrists on a part-time basis also is being explored.

SWVTC regularly keeps Central Office informed of changes in psychiatric coverage. SWVTC will continue efforts to increase the number of on-site psychiatric hours of service, with the goal of providing at least 16 hours of on-site service per month.

OIG Comment (June 2003) – *Members of the OIG review team were informed that SWVTC has been able to advertise for a full-time psychiatrist as a component of a*

regional dually diagnosed program slated for opening in the Fall. The program will serve persons diagnosed with mental retardation who are also experience active symptoms of an acute mental illness from the Southwestern Virginia region who could benefit from a comprehensive assessment and short-term (less than 90 days) structured programming with the goal of successful reintegration into the community. A percentage of the psychiatrist time will be devoted to providing coverage for this program, but the individual will also address the psychiatric needs of other facility residents, as appropriate. Currently SWVTC has been using a part-time psychiatrist on a short-term contract to provide coverage. This finding will remain ***ACTIVE*** *until, the position has been filled and coverage stabilized.*

Status Report: 7/03
Recruitment for the position in on going and will continue until the position in filled. The position requires an advanced professional degree. The date when the position will be filled is unknown at this time.

Finding 2.5: SWVTC would benefit from the addition of a PhD level psychologist.

Recommendation: Review options for securing this position in order to enhance treatment services.

DMMRSAS Response: Such a position is a priority for staffing enhancement at SWVTC. Efforts will continue to fund such a position. One option being explored is transfer of psychologist(s) to SWVTC from a psychiatric facility as part of the current system re-structuring initiative.

OIG Comment (June 2003) *– Members of the OIG review team was informed that the facility has recently advertised for a full-time doctorate level clinical psychologist and anticipates that this position will be filled within the next six to eight weeks. This person will serve as the Director of Psychology, providing clinical supervision for the Master's level psychologists at the facility. In addition, the individual will provide assessment and treatment recommendations for person involved in a regional dually diagnosed program slated for opening at the facility in the fall. This finding will remain* ***ACTIVE*** *until, the position has been filled and coverage stabilized.*

Status Report: 7/03
Recruitment for the position is on going and will continue until the position is filled. The position requires an advanced professional degree. The date that the position will be filled is unknown at this time.